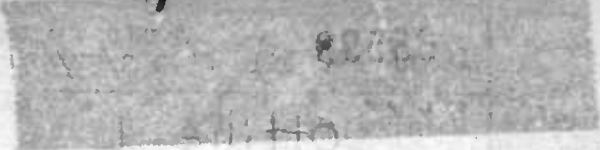


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03579											
Item 3 Film G399 3/27/68 kk CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Ottillie L Ackermann						2a. DATE OF DEATH March 10 Day 1968			2b. HOUR 7:25 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 12-2-1880		6. AGE (In years last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Carmichael, MD			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Foxleigh Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD Md.			13b. COUNTY Balto; Co		13c. CITY OR TOWN Carmichael		13d. INSIDE CITY LIMITS? YES NO <input type="checkbox"/>		13e. STREET AND NUMBER 3400 Fairview Ave		
14. FATHER'S NAME First Uluch Middle Weiblinger Last Uluch				15. MOTHER'S MAIDEN NAME First Katherine Middle ? Last ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) no (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Ottillie Dockins, 3400 Fairview Ave; 21207 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Diabetes Mellitus											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-4 , 19 67 , to 3-10 , 19 68 , that (I) (we) lost saw the deceased alive on 2-15 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David J. Miller DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 3-10-68					
22d. PHYSICIAN'S NAME (Type) David J. Miller						22e. ADDRESS Lisian Rd. Owings Mills, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 3-13-68		23c. NAME OF CEMETERY OR CREMATORY Loudon Pk. 21133		23d. LOCATION (City or Town) (County) (State) 3801 Frederock Ave. 21228					
24. FUNERAL DIRECTOR Loring Byers, 8728 Liberty Rd; Randallstown, Md. ADDRESS						25a. REC'D BY REGISTRAR MAR 13 1968 DATE		25b. REGISTRAR'S SIGNATURE Charles Judge			

07330



Official location, also receiving area: 100

Elmington

Director to Secretary

Executive Director

Director

United States Liberty Bell, Philadelphia, Pa.
1920

100 Elmington Ave. 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03600

03580

1. DECEASED-NAME (Type or print) Mark Douglas Adams			2a. DATE OF DEATH Month 3 Day 31 Year 1968			2b. HOUR 6:45 a <input checked="" type="checkbox"/> m <input type="checkbox"/>					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5/2/1957		6. AGE (In years last birthday) 10 YRS.		IF UNDER 1 YEAR MONTHS 10 DAYS 10 HOURS 10 MIN.			
7a. BIRTHPLACE (State or foreign country) York, Pa.		7b. CITIZEN OF WHAT COUNTRY? by birth		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.					
10. CITY OR TOWN OF DEATH Owings Mills			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Route 1, Box 218		
14. FATHER'S NAME First Middle Last Samuel Shelby Adams III			15. MOTHER'S MAIDEN NAME First Middle Last June Gray								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. —		17. INFORMANT Rosewood Records						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pericarditis 510X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 512X (b) Atelectasis left pulmonary total DUE TO, OR AS A CONSEQUENCE OF (c) Empyema left pleural marked								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days			
								2 months			
								2 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Acute Hurler's Syndrome & Severe Mental Retardation 8 1/2 yrs											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Oct. 29, 1963 to Mar. 31, 1968 , that (I) (we) lost saw the deceased alive on Mar. 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Richard A. Jones								DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/1/68	
22d. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.								22e. ADDRESS Rosewood State Hosp., Owings Mills, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Black Rock			23d. LOCATION (City or Town) (County) (State) Butler, Baltimore, Md.			
24. FUNERAL DIRECTOR John Harkins R.H.P.					ADDRESS Delta Pa 17314		25a. REC'D BY REGISTRAR DATE APR 4 - 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		

03280

03280

03280

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03601

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03581

1. DECEASED-NAME (Type or Print) Archibald R. Aiken			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 3-16-68 2b. HOUR 168-10		
3. SEX Male	4. RACE White	5. DATE OF BIRTH May 2, 1886	6. AGE (in years last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Iowa		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Sparrows Point			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1228 Beechwood Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machine Operator
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Sparrows Point	
14. FATHER'S NAME William Aiken			15. MOTHER'S MAIDEN NAME Margaret Shaw		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I		16b. SOCIAL SECURITY NO. 213-07-0782		17. INFORMANT ADDRESS Balt. Md. 21222 (Daughter) Mrs. Betty Gould, 3224 Lynch Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility - DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. 1228 Beechwood Rd. City or Town Sparrows Pt. County Balt. State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE MB Davis M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Mornington Rd. EXAMINER'S NAME (Type) Melvin B. Davis M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 22b. DATE SIGNED March 20, 1968 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Dundalk, Md. 21222					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/22/68		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave.		ADDRESS Dundalk Md.		25a. REC'D BY REGISTRAR MAR 26 1968	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

1856

2030

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03602		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03582		9 ⁵⁵ 9 ^{Am}			
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Charles		Gerard		Aiken		Jr		Month Day Year 3 23 68		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
male		white		May 24, 1916		51 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		U. S.				Baltimore				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Catonsville		SPRING GROVE STATE HOSP.		Consultant		Insurance					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Balto.		Towson		YES <input type="checkbox"/> NO <input type="checkbox"/>		1637 Aberdeen Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
(Jerry)		Charles		Gerald		Aiken Sr.		Mary		J. McKenna	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address					
Navy		1942-45		214 06 9498		Records: SPRING GROVE STATE HOSPITAL					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 months +		8 years		8 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Brain Tumor with Left Hemiplegia</u>				7 months +							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
none											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
none											
22a. I certify that (X) (this hospital) attended the deceased from <u>Dec. 9</u> , 1967, to <u>March 23</u> , 1968, that (I) (we) last saw the deceased alive on <u>March 23</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>at 9:55 AM</u>											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
<i>Imre Kopits</i>		March 23, 1968		Imre Kopits, M.D. (Md. Lic. K-7077)		SPRING GROVE STATE HOSPITAL					
						Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		3-26-68		St. Johns Cath Cemetery		Hyde, Maryland (Balto. Co)					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Wm. E. Johnson, 8521 Loch Raven Blvd. Balto.				DATE		MAR 27 1968					
				21204							

59350

58220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR 2 A M		
J.			HALL		AIKEN, JR				MAR 1 1968				
3. SEX M		4. RACE CAU		5. DATE OF BIRTH NOV. 17, 1909				6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH BALTIMORE Md.							
10. CITY OR TOWN OF DEATH TOWSON			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8426 Lock Raven Blvd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Telle. Com. Oper. - Tole			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Towson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8426 Lock Raven Blvd.				
14. FATHER'S NAME J.			First		Middle		Last		15. MOTHER'S MAIDEN NAME Virginia Kelley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO			16b. SOCIAL SECURITY NO. 214-26-342		17. INFORMANT MRS. Agnes Aiken, Same as #13			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL HEART DISEASE COMPLICATED 421.0 DUE TO, OR AS A CONSEQUENCE OF BY BACTERIAL ENDOCARDITIS. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) SEPERATION OF AORTIC VALVE PROSTHESIS											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH BIRTH 5 Yrs 2 Yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4300													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from June, 1963, to March 1, 1963, that (I) (we) lost saw the deceased alive on 1/26 1963, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Donald H. Dembo MD						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/1/68			
22d. PHYSICIAN'S NAME (Type) DONALD H. DEMBO						22e. ADDRESS 827 LINDEN AVE. BALTO 21201							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 3/4/68		23c. NAME OF CEMETERY OR CREMATORY MORELAND			23d. LOCATION (City or Town) (County) (State) BALTIMORE Md					
24. FUNERAL DIRECTOR Wm Cook. Brooks Towson			ADDRESS 1050 York Rd TOWSON MD 21204			25a. REC'D BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE John H. Judge					

03603

REMARKS OF DEPT.

03603

7

THIS REPORT IS THE PROPERTY OF THE U.S. GOVERNMENT
IT IS LOANED TO YOUR AGENCY AND IS NOT TO BE
REPRODUCED OR TRANSMITTED IN ANY FORM OR BY
ANY MEANS, ELECTRONIC OR MECHANICAL, INCLUDING
PHOTOCOPYING, RECORDING, OR BY ANY INFORMATION
STORAGE AND RETRIEVAL SYSTEM, WITHOUT PERMISSION
IN WRITING FROM THE NATIONAL ARCHIVES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03604												03584											
1. DECEASED-NAME (Type or print) First Middle Last												2a. DATE OF DEATH Month Day Year											
SAMUEL ALMONY												MAR 10 1968 2:13 PM											
3. SEX Male				4. RACE White				5. DATE OF BIRTH Oct. 5, 1892				6. AGE (In years lost birthday) 75 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Md.-				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Balt.to.-				Md.							
10. CITY OR TOWN OF DEATH Parkton				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Stablers Church Rd.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Foreman				12b. KIND OF BUSINESS OR INDUSTRY Highway Dept.											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Balt.to.				13c. CITY OR TOWN Parkton				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER Stablers Church Rd.-							
14. FATHER'S NAME First Middle Last unknown						15. MOTHER'S MAIDEN NAME First Middle Last Ida Almony																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. 212-40-5400				17. INFORMANT Mrs. Catherine A. Almony				Address Parkton, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of mandible & metastases																							
1701 DUE TO, OR AS A CONSEQUENCE OF																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
(b) DUE TO, OR AS A CONSEQUENCE OF																							
(c)																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
1961																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from 1964, to 3/10/68, 19, that (I) (we) last saw the deceased alive on 3/9/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE C. M. France M.D. DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 3/10/68							
22d. PHYSICIAN'S NAME (Type) A. M. FRANCE M.D.												22e. ADDRESS PARKTON, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 3/13/68				23c. NAME OF CEMETERY OR CREMATORY West Liberty Cem.				23d. LOCATION (City or Town) (County) (State) Whitehall, Balto., Md.											
24. FUNERAL DIRECTOR J. Jacob Hartenstein, New Freedom, Pa.												25a. REC'D BY REGISTRAR DATE MAR 13 1968				25b. REGISTRAR'S SIGNATURE Charles Judge							

MEDICAL CERTIFICATION

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1000 1/2 N. 1st St. St. Paul, Minn.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

03605		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03585			
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM MCKINLEY ARNOLD						2a. DATE OF DEATH Month Day Year March 11 1968		2b. HOUR P 2:45M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH January 2 1898		6. AGE (In years last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.			
10. CITY OR TOWN OF DEATH Fort Howard		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Professional sailor		12b. KIND OF BUSINESS OR INDUSTRY US Navy			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Town		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Box 627 R t 1, Jarrettsville	
14. FATHER'S NAME First Middle Last Charles H. Arnold		15. MOTHER'S MAIDEN NAME First Middle Last Virginia T. Weathersteine							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes		16b. SOCIAL SECURITY NO. PL89 217 09 36 56		17. INFORMANT Address Clinical Rcds., VA Hospital, Ft Howard, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) ADHESIVE PERICARDITIS WITH CARDIAC DECOMPEN- SATION DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF RIGHT LUNG WITH METASTASES TO DUE TO, OR AS A CONSEQUENCE OF (c) BRAIN AND LIVER Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from June 1, 1965 , to March 11, 1968 , that (X) (we) last saw the deceased alive on March 11, 1968 , and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. D. Talbert MD		DEGREE M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3/12/68			
22d. PHYSICIAN'S NAME (Type) J. D. TALBERT, M.D.		22e. ADDRESS VA Hospital, Fort Howard, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-15-68		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR William E. Johnson		ADDRESS 8521 Loch Raven Blvd. Baltimore, Maryland 21218		25a. REC'D BY REGISTRAR DATE MAR 14 1968		25b. REGISTRAR'S SIGNATURE J. D. Talbert			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03606

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03586

1. DECEASED-NAME (Type or print) JOSEPH			First Middle Last ----- ATWOOD			2a. DATE OF DEATH Month March Day 13 Year 1968			2b. HOUR P. Min 6:15		
3. SEX Male			4. RACE Negro			5. DATE OF BIRTH Jan. 2, 1898			6. AGE (In years last birthday) 70 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Fort Howard			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Veterans Administration			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR INDUSTRY Naval Academy		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Anne Arundel			13c. CITY OR TOWN Annapolis			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Eelzie Middle Atwood Last Atwood			15. MOTHER'S MAIDEN NAME First Mary Middle Ross Last Ross								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) WW-1			16b. SOCIAL SECURITY NO. 215 12 95 97			17. INFORMANT Address Clinical Rcds VA Hospital, Fort Howard, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO CONGESTIVE CARDIAC FAILURE 571.8 DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE ULCER OF STOMACH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) CIRRHOSIS OF LIVER, MILD DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5810											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (this hospital) attended the deceased from March 5, 1968 , to March 13, 1968 , that (we) lost saw the deceased alive on March 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Madhav D. Barkanpurkar DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>									22c. DATE SIGNED 3/14/68		
22d. PHYSICIAN'S NAME (Type) MADHAV D. BARKANPURKAR, M.D.									22e. ADDRESS VA Hospital, Fort Howard, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/18/68			23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR William Reese Funeral Home						25a. REC'D BY REGISTRAR MAR 15 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

03607

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03587

1. DECEASED-NAME (Type or print) Maria A. Auld			First Middle Last			2a. DATE OF DEATH Month Day Year 3-21-68			2b. HOUR 12:34 P.M.		
3. SEX Female			4. RACE W			5. DATE OF BIRTH Feb. 2, 1902			6. AGE (In years last birthday) 66 YRS.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Balto Co Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1056 Craftswood Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY U.S.A.			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 1056 Craftswood Rd.			14. FATHER'S NAME First Middle Last Henry Jakiewicz			15. MOTHER'S MAIDEN NAME First Middle Last Lena Sipoch					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO. 212-10-2409A			17. INFORMANT Mrs. Frances Karr, Balto., Md. 21207			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease with myocardial infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4201											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1962 , to 3-21, 1968 , that (I) (we) last saw the deceased alive on 2-17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John A. Nesbitt, Jr.			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 3-22-68		
22d. PHYSICIAN'S NAME (Type) John A. Nesbitt, Jr., M.D.			22e. ADDRESS 1009 Frederick Road								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3-25-68			23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery			23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR Witzke F. D., Balto., Md. 21229			ADDRESS 4101 Edmondson Avenue			25. RECEIVED BY REGISTRAR MAR 26 1968			25b. REGISTRAR'S SIGNATURE Francis Judge		

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03608 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 13 Film G398 3/13/68
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0358A

1. DECEASED-NAME (Type or Print) First Middle Last Ida Katherine Bailey			2a. DATE KNOWN OF DEATH Month Day Year March 6 1968			2b. HOUR OF DEATH 3:12 PM		
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH 12-23-1877	6. AGE (In years last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year March 6 1968		
7a. BIRTHPLACE (State or foreign country) Dagsboro, Del.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Baltimore Md.		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Armacost Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Hardware		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 2916 Grindon Avenue 8121 Hobbsville Avenue
14. FATHER'S NAME First Middle Last John Dukes			15. MOTHER'S MAIDEN NAME First Middle Last Katherine Evans					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-12-7060		17. INFORMANT ADDRESS Mrs Virginia Bailey 4621 Araba Avenue 21214				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Edema + Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Fracture of Left Hip</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 months</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>9007</u>								
19a. DATE OF OPERATION <u>1/6/68</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Fracture of Left Hip</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year Hour A.M. P.M. <u>6:00 P.M. March 6 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fall downstairs 2 steps from 2nd Floor</u>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. <u>Baltimore</u>		City or Town County State <u>Baltimore Md</u>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/6/68</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>3-8-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Co. Md.</u>		
24. FUNERAL DIRECTOR <u>Lansdown Funeral Home 7401 Belair Road</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

03609		M		03589			
1. DECEASED-NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month Day Year	2b. HOUR p. M	
Wenonah		B.		Baltz	March 14, 1968	1:30 p. M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
female	white	July 23, 1885		82 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY		
Md.	U. S.	Baltimore		Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Catonsville	SPRING GROVE STATE HOSP.		housewife - Saleslady				
13a. USUAL RESIDENCE (Where deceased admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Md.	Balto.	Gwynn Oak		5013 Gwynndale Avenue			
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last
Frank				Ella			Anderson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT				
		492-16-9224A	Records: SPRING GROVE STATE HOSPITAL				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>485 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>491 X</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (X) (this hospital) attended the deceased from <u>Feb. 2</u> , 19 <u>68</u> , to <u>March 14</u> 19 <u>68</u> , that (X) (we) lost saw the deceased alive on <u>March 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Anthony J. Young, M.D.</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 3-14-68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Baltimore, Maryland 21228</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL	3-18-68	Mount Evergreen Cemetery		Mills, Ill. Nois			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
Ellsworth Armacost		4600 Liberty Heights Ave.		MAR 15 1968		Charles Judge	

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print) <i>Eleanor</i>			First <i>White</i>			Middle <i>Barr</i>			Last			2a. DATE OF DEATH <i>3 26 68</i> Month - Day - Year			2b. HOUR <i>7:15 PM</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>12/31/91</i>			6. AGE (In years last birthday) <i>76</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign) <i>Bellevue Ohio</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH <i>Baltimore</i> Md.								
10. CITY OR TOWN OF DEATH <i>Baltimore</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>G.B.M.C.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>housekeeper</i>			12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>Balto</i>			13c. CITY OR TOWN <i>Balto</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>2601 Madison Ave</i>					
14. FATHER'S NAME First <i>L.W.</i> Middle <i>Barr</i> Last <i>(Rev.)</i>			15. MOTHER'S MAIDEN NAME First <i>Maggie</i> Middle <i>Hicks</i> Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>N.A.</i>			16b. SOCIAL SECURITY NO. <i>215-32-3533</i>			17. INFORMANT <i>Dr. Charet</i>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiorespiratory arrest</i> <i>427.2</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>congestive heart failure & fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>434.1 old age</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>3-22-1968</i> , to <i>3-26-1968</i> , that (I) (we) last saw the deceased alive on <i>4-5-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>E. Abtahian</i>			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>3-26-68</i>								
22d. PHYSICIAN'S NAME (Type) <i>E. ABTAHIAN</i>			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>3/30/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>			23d. LOCATION (City or Town) (County) (State) <i>Farmount W. Va</i>								
24. FUNERAL DIRECTOR <i>Witzke</i>			ADDRESS <i>4101 Edmondson Ave</i>			25a. REC'D BY REGISTRAR <i>MAR 27 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>								

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A. J.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03592

| | | | | | | | | | | | |
|---|--|---|---|---|---|--|--|---|--|------------------------------------|--|
| 1. DECEASED-NAME (Type or print)
First Anna Middle Frances Last BARRY | | | 2a. DATE OF DEATH
Month March Day 18, Year 1968 | | | 2b. HOUR P.
1:15 P. | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 3, 1921 | | 6. AGE (In years lost birthday)
46 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Claim Representative | | 12b. KIND OF BUSINESS OR INDUSTRY
Social Security | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
808 Exeter Hall Ave. | | | |
| 14. FATHER'S NAME First Michael Middle Lanasa Last | | | 15. MOTHER'S MAIDEN NAME First Mary Middle E. Last Mullen | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
213-16-5238 | | | 17. INFORMANT Address
William Barry, 808 Exeter Hall Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>
410.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/14/</u> , 19 <u>68</u> , to <u>3/18/</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/18/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>William</u> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 18, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Inez Cilliani, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Moreland | | 23d. LOCATION (City or Town)
Balto., Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc., 5305 Harford Rd. | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAR 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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Edward J. Buck, Jr., 2302 Madison St.

Environ Biol Fish (2015) 98:103–114

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|--|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 03612 | | | | | | | | | |
| 03593 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) KATHRINE M. BARRY | | | | | 2a. DATE OF DEATH
MARCH 20, 1968 | | | 2b. HOUR
M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
June 22, 1886 | | 6. AGE (In years
last birthday)
81 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Newark, Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | Md. | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
118 N. Beechwood Ave. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. CITY
Baltimore | | 13c. CITY OR TOWN
Catonsville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
118 N. Beechwood Ave. | |
| 14. FATHER'S NAME
First Middle Last
James Daniel O'Shaughnessy | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Mary Ellen O'Neil | | | Address
Mrs Mary Kathleen Johnson 118 N. Beech | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) (If yes give war or dates of service)
no none none | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT
Mrs Mary Kathleen Johnson 118 N. Beech | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ca. of Rectum
154.1
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
154X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19, 1968 , to March 20, 1968 , that (I) (we) last
saw the deceased alive on March 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
J. C. Pound | | DEGREE
M.D. | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/22/68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
J. C. Pound | | 22e. ADDRESS
3325 Frederick Ave | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
March 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemt. Baltimore, Maryland | | 23d. LOCATION (City or Town) (County) (State) | | | |
| 24. FUNERAL DIRECTOR
Steeling Funeral Estate
756 Edmondson Ave.
Catonsville, Md. 21228 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

03813

03813

General Practice
1913
1913

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03613

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03594

| | | | | | | | | |
|--|------------------|---|--|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or Print) Laura Ashton Bartosovich | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 3 Day 6 Year 1968 | | | 2b. HOUR 5:24 M AM | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH 1/27/09 | 6. AGE (in years last birthday) 59 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | 2c. DATE PRONOUNCED DEAD
Month March Day 6 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Lansdown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 21 Third Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) tool grinder | | 12b. KIND OF BUSINESS OR INDUSTRY metal | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. | | 13b. COUNTY Balto. | | 13c. CITY OR TOWN Jandobun | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 21 Third Ave. |
| 14. FATHER'S NAME
First John Middle W. Last Acord | | | 15. MOTHER'S MAIDEN NAME
First Elizabeth Middle Overholt | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 214-22-7399 | | 17. INFORMANT Mr. Paul Acord | | ADDRESS 1005 Dunholme Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Vascular Disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ State _____ |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE James N. Frederick | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 3/6/68 | | |
| EXAMINER'S NAME (Type) James N. Frederick MD | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 1311 Lianan Ave | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | Balto. Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 3/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cem. | | 23d. LOCATION (City or Town) (County) (State) Balto. Md. | |
| 24. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker | | | | ADDRESS Sts. | | 25a. REC'D BY REGISTRAR MAR 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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MAY 2 1968

Division of Field [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|------------------------------------|--|----------------|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | |
| DAVID | | | K. | | BAUM | | MARCH 12, 1968 | | 2b. HOUR 11 P.M. | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | |
| MALE | | | WHITE | | | | | | 80 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | |
| BALTIMORE, MD. | | | U.S.A. | | | | | | BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| | | | 521 NASSAU STREET | | | MERCHANT | | | RETAIL | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13e. STREET AND NUMBER | |
| MARYLAND | | | BALTIMORE | | | | | | 521 NASSAU STREET | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| KARSHMAN | | | BAUM | | | UNKNOWN | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | |
| NO | | | | | | MRS. HELEN BAUM, c/o KENNETH BAUM 6804 WILLIAMSON AVENUE, BALTO. 21215 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>autochr. coronary insufficiency</u> | | | | | | | | | | 1 yr |
| 411.9 DUE TO, OR AS A CONSEQUENCE OF <u>arteriosclerosis</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4201 Adeno-Carcinoma of Prostate | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>67</u> , to <u>3/10</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Milton Kirsh</u> | | | | | | | | | | 22c. DATE SIGNED <u>3/13/68</u> |
| 22d. PHYSICIAN'S NAME (Type) MILTON KIRSH | | | | | | | | | | 22e. ADDRESS 4000 W. NORTHERN PKWY. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 3-14-68 | | BALTIMORE HEBREW | | | BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | RD. | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR SIGNATURE |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN | | | | | | | | MAR 18 1968 | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03615 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03596 | | | |
|--|--|--|--|--|--|---|--|------------------------|--|------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | |
| Margaret | | R. Beall | | March 1, 1968 | | 5:50 | | | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| female | | white | | April 15, 1882 | | 85 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| / Md. Penna. | | U. S. | | | | Baltimore | | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Catonsville | | SPRING GROVE STATE HOSPITAL | | housewife | | Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Harford | | Aberdeen | | | | R.F.D. #2 - Box 65 | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| Daniel Waters | | Mary Marsteller | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 219-36-0849 | | Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction, recent, with pro- | | 1 wk. | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) Arteriosclerotic cardiovascular Ht. Dis. | | 4 yrs. | | | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | (c) Arteriosclerosis, Generalized, senile | | 10 yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| none. 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Sept. 27, 1965, to March 1, 1968, that (X) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Anthony J. Young, M.D. | | 3-1-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Anthony J. Young, M.D. | | SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 4 Mar. 1968 | | Mt Zion Methodist Cemetery Bel Air (Harford) Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Tarring Funeral Home | | DATE MAR 4 1968 | | Charles Judge | | | | | | | |
| Aberdeen, Md. 21001 | | | | | | | | | | | |

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1994

1. The first group of people who are interested in the results of the study are the researchers themselves. They want to know if the study was successful in achieving its goals and if the data collected is reliable and valid. They also want to know if the study has contributed to the field of research and if it has provided any new insights or findings.

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03616 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 03597 | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---------------------|--|--|--|---------------------------|--|--|--|
| Items 12b, 15 & 16b Film G399 4/1/68 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | First
Henry | | | | Middle
W. | | | | Last
BECKMAN | | | | 2a. DATE OF DEATH
Month
March | | | | Day
27 | | | | Year
1968 | | | | 2b. HOUR
8:45AM | | | |
| 3. SEX
Male | | | | 4. RACE
White | | | | 5. DATE OF BIRTH
October 4, 1903 | | | | 6. AGE (In years
last birthday)
64 YRS. | | | | IF UNDER 1 YEAR
MONTHS
64 | | | | IF UNDER 24 HRS.
DAYS
64 | | | | HOURS
64 | | | | MIN.
64 | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Baltimore, | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Ex. Vice Pres. Braddock Co. | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
C.B. Briddell Co. | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | 13b. COUNTY
Baltimore | | | | 13c. CITY OR TOWN
Baltimore | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
3116 Juneau Place | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Peter Beckman | | | | Middle
 | | | | Last
 | | | | 15. MOTHER'S MAIDEN NAME
First
Catherine | | | | Middle
 | | | | Last
 | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
no | | | | (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
1212033245 | | | | 17. INFORMANT
Mrs. Evelyn Beckman--- | | | | Address
Same | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary thrombo-embolism
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last: 163X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Carcinoma of lung with metastasis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
March 8, 1968 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Metastatic carcinoma | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from 2/23/ , 19 68 , to 3/27/ , 19 68 , that (X) (we) last
saw the deceased alive on 3/27/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Reynaldo Orjuela-Gomez, M.D. | | | | DEGREE
 | | | | ATTENDING
PHYS. <input type="checkbox"/> | | | | MED.
DIRECTOR <input type="checkbox"/> | | | | STAFF
PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
March 27, 1968 | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | Reynaldo Orjuela-Gomez, M.D. | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE
3/30/68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck Inc. 5305 Harford Rd. | | | | ADDRESS
 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | | | | | | | | | | | | | | | |

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[Handwritten signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) BARNETT BEERMAN | | | First Middle Lost | | | 2a. DATE OF DEATH
3 Month 20 Day Year 68 | | 2b. HOUR
15 PM | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7-22-1886 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
RAN SAISTOWN MD. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Baltimore County Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SALESMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
JEWELRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3330 Virginia Ave. #15 | |
| 14. FATHER'S NAME
First Middle Lost
HILLEL BEERMAN | | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
SARAH ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
217-03-3801A | | 17. INFORMANT MARTIN BEERMAN Address
130 SLADE AVE., APT. 214 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic obstructive Pulmonary Disease
492X
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary Erythema
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
5271 Prostate Disease, POST TUR | | | | | | | | | | |
| 19a. DATE OF OPERATION
3-20-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
BPH | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-10-1968 , to 3-20-1968 , that (I) (we) last saw the deceased alive on 3-20-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Wenifredo N. Iglesias M.D. | | | | | | | | 22c. DATE SIGNED
3-20-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Wenifredo N. Iglesias | | 22e. ADDRESS
BALTIMORE COUNTY GENERAL HOSPITAL | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
2-22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
(ANSHE EMUNAH) AITZ CHAIM | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. INC. | | | | 25a. REC'D BY REGISTRAR
MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |
| 6010 REISTERSTOWN ROAD, BALTO. 21215 | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/66

| 03613 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03599 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (Type or print) <i>Elsie</i> | | | | | | | | | | First <i>C</i> Middle <i>Behsler</i> Last | | | | | | | | | | Month <i>March</i> Day <i>9</i> Year <i>1968</i> | | | | | | | | | | 145 M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX <i>F</i> | | | | | | | | | | 4. RACE <i>W</i> | | | | | | | | | | 5. DATE OF BIRTH <i>1-11-08</i> | | | | | | | | | | 6. AGE (In years lost birthday) <i>60</i> YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto.</i> | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Randallstown</i> | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Balto. Co. Gen. Hosp.</i> | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Secretary</i> | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Balto Lumber</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | | | | | | | | 13b. COUNTY <i>Balto.</i> | | | | | | | | | | 13c. CITY OR TOWN <i>Balto.</i> | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER <i>3517 W. Paton Ave.</i> | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address <i>Irma C. Bock 304 S. Monroe St. Balto.</i> | | | | | | | | | | | | | | | | | | | |
| First <i>George</i> | | | | | | | | | | Middle <i>Behsler</i> | | | | | | | | | | Last <i>Margaret</i> | | | | | | | | | | First <i>Snyder</i> | | | | | | | | | | Middle <i></i> | | | | | | | | | | Last <i></i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Terminal Aspiration, massive</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Gastric Distention</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Pancreas & Metastases</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Hours</i> <i>Hours</i> <i>Months</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>March 5</i> , 19 <i>68</i> , to <i>March 9</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>March 9</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <i>Wenifredo N. Iglesia M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <i>3-9-68</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Wenifredo N. Iglesia</i> | | | | | | | | | | 22e. ADDRESS <i>Baltimore, Maryland</i> | | | | | | | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | | | | | | | 23b. DATE <i>Tues. 3/12/68</i> | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park</i> | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore Maryland</i> | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>Witzke F.D.</i> | | | | | | | | | | ADDRESS <i>4101 Edmondson Ave. Balto. Md.</i> | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAR 12 1968</i> | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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First C. Beasley

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Washington

George Washington University

3015 N. Lynn Ave.

Washington

James A. Smith, Jr. N. Smith St. Wash.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03619

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03600

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) MILDRED PEARL BEM | | | 2a. DATE OF DEATH
Month 9 Day 8 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7-5-00 | | 6. AGE (In years lost birthday)
67 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREAT BALTO MEDICAL Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Home maker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
First John Middle CRANFORD Last ANNA | | 15. MOTHER'S MAIDEN NAME
First ETCHISON Middle ETCHISON Last ETCHISON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
213-12-2081 | |
| 17. INFORMANT
As. inf. chart | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
174X
DUE TO, OR AS A CONSEQUENCE OF
(b) Metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1.19 , 19 68 , to 3.8 , 19 68 , that (I) (we) last saw the deceased alive on 3.8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
DIPAK K. Mallik | | DEGREE
DIPAK K. MALLIK | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3.8.68 | |
| 22d. PHYSICIAN'S NAME (Type)
DIPAK K. MALLIK | | 22e. ADDRESS
9. B. M. C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
John C. Miller Inc-6415 Belair Rd. | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 13 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

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UNITED STATES

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

06593

| | | | | | |
|---|--|--|---|--|---------------------------|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Harry Charles Louis BESTLAND | | | 2a. DATE OF DEATH
Month Day Year
March 25, 1968 | | 2b. HOUR
7:26AM |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
March 23, 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS
1 1 1/2 | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
29 Fox Club Lane | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
Harry Leonard C. Bestland | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Marykatherine Hedwig Alley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive pulmonary atelectasis
7769
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
7620 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/23/ , 19 68 , to 3/25/ , 19 68 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on 3/25/ , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ines Cilliani, M. D. | | | | 22c. DATE SIGNED
March 25, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M. D. | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE
5/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
U. of Md. Med School | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR
DATE MAY 20 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03620 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03601 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | First Middle Last | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| JOSEPH A BIALEK | | | | | | | | | | | | | | | | | | | | MARCH 1st 1968 11:30 PM | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| Male | | | | | White | | | | | 2/14/08 | | | | | 60 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Baltimore, Maryland | | | | | U.S.A. | | | | | | | | | | Baltimore County Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Fort Howard | | | | | Veterans Administration Hospital | | | | | Clerk | | | | | Gas & Elec. Co. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | -- | | | | | Baltimore | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 2816 Hudson Street | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Joseph Bialek | | | | | Catherine Lebadowicz | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| Yes WW II | | | | | 212-05-5012 | | | | | Clinical Records, VAH, Fort Howard, Maryland | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u>
<u>431.0</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause lost.
(b) <u>CEREBRAL ARTERIOSCLEROSIS</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>HYPERTENSIVE VASCULAR DISEASE</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>331X</u> | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | DAYS | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28</u> , 1968, to <u>March 1</u> , 1968, that (we) last saw the deceased alive on <u>March 1</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Heiler Neilson M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED <u>3/2/68</u> | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>NEILON NEILSON, M.D.</u> | | | | | | | | | | 22e. ADDRESS <u>VA Hospital, Fort Howard, Maryland</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 3/5/68 | | | | | Holy Rosary Cemetery | | | | | Baltimore, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| John J. Duda Funeral Home | | | | | | | | | | 2829 Hudson Street Baltimore, Maryland | | | | | | | | | | MAR 4 1968 | | | | | | | | | |

40350

135920

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
M | |
|--|--|--|---|--|--------------------------------|---|---|--|---|--|-------------------------------|
| MARY FRANCES BIANCA | | | | | | | MARCH 17, 1968 | | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
DECEMBER 6, 1965 | | | 6. AGE (In years last birthday)
2 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
60 MURDOCK RD. #21212 | | |
| 14. FATHER'S NAME
First Middle Last
FRANCIS J. BIANCA | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
CAROL A McGraw | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Francis J Bianca same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE LYMPHOCYTIC LEUKEMIA
2040
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
2040 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from JANUARY 30, 1968, to MARCH 17, 1968, that (I) (we) last saw the deceased alive on MARCH 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Beatriz P. Dizon DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
3-17-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Beatriz P. Dizon, M.D. | | | | 22e. ADDRESS
7620 York Road, Baltimore, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION, REBURY (Type)
Burial | | 23b. DATE
3/19/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley | | | 23d. LOCATION (City or Town) (County)
Baltimore, Maryland | | 21204 (State) | | |
| 24. FUNERAL DIRECTOR
Leonard Ruck Inc. Baltimore, Md | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

02805

02805

1. The first part of the document is a list of names and addresses, which are arranged in a table-like format. The names are written in a cursive script, and the addresses are written in a more formal, printed style. The list includes names such as "John Smith", "Mary Jones", and "Robert Brown", along with their respective addresses in various cities and states.

2. The second part of the document is a series of paragraphs of text, which appear to be a letter or a report. The text is written in a cursive script and is somewhat difficult to read due to the handwriting. It seems to be a personal communication, possibly a letter to a friend or a family member, discussing various topics and events.

3. The third part of the document is a list of names and addresses, similar to the first part. This list also includes names and addresses, but it is less extensive than the first list. It appears to be a continuation of the same information or a separate list of contacts.

4. The fourth part of the document is a series of paragraphs of text, similar to the second part. This text is also written in a cursive script and is somewhat difficult to read. It seems to be another personal communication, possibly a letter or a report, discussing various topics and events.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03622 | | | | | | | | | | 03603 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | | Middle | | | Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| MILDRED | | | Lee | | | BIEBL | | | MARCH | | | Month 30, Day 1968 Year | | | 11:50 P | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | |
| FEMALE | | | WHITE | | | JUNE 1, 1906 | | | 61 YRS. | | | MONTHS | | | DAYS | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | |
| MARYLAND | | | U.S.A. | | | | | | BALTIMORE, Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | |
| TOWSON | | | ST. JOSEPH HOSPITAL | | | HOMEMAKER | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | |
| MARYLAND | | | — | | | BALTIMORE | | | | | | 111 S. CASTLE STREET #21231 | | | | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | |
| George | | | Behrns | | | Margaret Mueller | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | |
| No | | | 212-01-4021 | | | Frank Biebl | | | 111 S Castel Street | | | 21231 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary insufficiency | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) probable osteogenic sarcoma of left thigh | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| with massive metastasis to lung. | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 1967 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| HOUR A.M. Month Day Year | | | P.M. | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | Street or R.F.D. No. | | | City or Town | | | County | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from MARCH 17, 1968, to MARCH 30, 1968, that (X) (we) last saw the deceased alive on MARCH 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | |
| Samuel Lee, M.D. | | | March 31, 1968 | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | | | |
| | | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) | | | (State) | | | | |
| Burial | | | April 3 1968 | | | Loudon Park Cemetery | | | 3801 FREDERICK AVE MD | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | |
| THE DIPPEL BROS INC 1800 E LOMBARD ST | | | DATE APR 3 - 1968 | | | Charles Judge | | | | | | | | | | | | | |

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

03623

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03604

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--------------------------|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) WALTER Andrew Bisker | | | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year MAR 23 1968 | | | 2b. HOUR 11:00 PM | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH 11-14-1899 | | | 6. AGE (In years last birthday) 68 YRS. | | | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | | 2c. DATE PRONOUNCED DEAD Month Mar Day 23 Year 1968 | | | 2d. HOUR 11:00 PM | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH CITY LOCK RIDGE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8347 RIDGELY OAK ROAD | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY PLUMBERS HALL | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | | 13b. COUNTY BALTIMORE | | | 13c. CITY OR TOWN LOCKRIDGE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 8347 RIDGELY OAK ROAD | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First JOHN Middle BISKER Last BISKER | | | 15. MOTHER'S MAIDEN NAME First M Middle KANE Last KANE | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO. 212-07-2718 | | | 17. INFORMANT ADDRESS MARGARET BISKER 8347 RIDGELY OAK ROAD | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cirrhosis of liver
571.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Terminal Gastrointestinal Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
undet. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5810 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John C. Hyle | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED 3-23-68 | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) JOHN C. Hyle | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or county) 7527 Belair Rd | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | | 23b. DATE 3/27/68 | | | | | | 23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER | | | | | | 23d. LOCATION (City or Town) (County) (State) BELAIR RD BALTO MD | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR LEO G. COOK | | | | | | ADDRESS 7200 HARFORD ROAD | | | | | | 25a. REC'D BY REGISTRAR MAR 26 1968 | | | | | | 25b. (Signature) [Signature] | | | | | | | | | | | |

03880

03880

03880

Handwritten notes and signatures, including a large circular stamp in the lower left corner.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>03624</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03605</div> | | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) First IRA Middle W. Last BLACK, SR. | | | | | | 2a. DATE OF DEATH
Month MARCH Day 22 Year 1968 | | | 2b. HOUR
2:50A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
4/8/91 | | | 6. AGE (In years last birthday)
76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
CONNECTICUT | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
COLONEL, US ARMY | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND | | | 13b. COUNTY ANNE ARUNDEL | | | 13c. CITY OR TOWN GIBSON ISLAND | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First E. L. NATHAN Middle BLACK Last | | | | | | 15. MOTHER'S MAIDEN NAME First HARRIETT Middle WOODRUFF Last | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (state or unknown) YES | | | | 16b. SOCIAL SECURITY NO. WW 1 - RETIRED 219 34 44 40 | | 17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS, LEFT CORONARY ARTERY
410.9
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 420.1
DUE TO, OR AS A CONSEQUENCE OF
(b) PULMONARY ABSCESS
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROTIC HEART DISEASE | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
RECENT
OLD | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
BENIGN PROSTATIC HYPERTROPHY, OLD. CEREBRAL ATROPHY, OLD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month Day Year
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that 24 (this hospital) attended the deceased from 2/13/68 , 19 , to 3/22/68 , 19 , that 4 (we) last saw the deceased alive on 3/22/68 , 19 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, 40 (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Howard C. Kramer | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/22/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) HOWARD C. KRAMER, M. D. | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3 March 68 | | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NATIONAL CEMETERY ARLINGTON, VIRGINIA | | | | 23d. LOCATION (City or Town) (County) (State)
 | | | |
| 24. FUNERAL DIRECTOR
Joseph GOWLER | | ADDRESS
WISCONSIN & HARRISON | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |
| DATE MAR 27 1968 ST. WASHINGTON, D.C. | | | | | | | | | | | |

48360

40360

[illegible]

DATE: 10/10/1964

100-100000 100-100000 100-100000

80,351

2015/5

63/55/E

60,321

CHATHAM, GRANT TOWN, N.Y.

1. D. ...

1. **NAME** _____
 2. **DATE** _____
 3. **TIME** _____
 4. **LOCATION** _____
 5. **REASON** _____
 6. **WITNESSES** _____
 7. **SIGNATURE** _____
 8. **INITIALS** _____
 9. **REMARKS** _____
 10. **DATE** _____
 11. **TIME** _____
 12. **LOCATION** _____
 13. **REASON** _____
 14. **WITNESSES** _____
 15. **SIGNATURE** _____
 16. **INITIALS** _____
 17. **REMARKS** _____
 18. **DATE** _____
 19. **TIME** _____
 20. **LOCATION** _____
 21. **REASON** _____
 22. **WITNESSES** _____
 23. **SIGNATURE** _____
 24. **INITIALS** _____
 25. **REMARKS** _____
 26. **DATE** _____
 27. **TIME** _____
 28. **LOCATION** _____
 29. **REASON** _____
 30. **WITNESSES** _____
 31. **SIGNATURE** _____
 32. **INITIALS** _____
 33. **REMARKS** _____
 34. **DATE** _____
 35. **TIME** _____
 36. **LOCATION** _____
 37. **REASON** _____
 38. **WITNESSES** _____
 39. **SIGNATURE** _____
 40. **INITIALS** _____
 41. **REMARKS** _____
 42. **DATE** _____
 43. **TIME** _____
 44. **LOCATION** _____
 45. **REASON** _____
 46. **WITNESSES** _____
 47. **SIGNATURE** _____
 48. **INITIALS** _____
 49. **REMARKS** _____
 50. **DATE** _____
 51. **TIME** _____
 52. **LOCATION** _____
 53. **REASON** _____
 54. **WITNESSES** _____
 55. **SIGNATURE** _____
 56. **INITIALS** _____
 57. **REMARKS** _____
 58. **DATE** _____
 59. **TIME** _____
 60. **LOCATION** _____
 61. **REASON** _____
 62. **WITNESSES** _____
 63. **SIGNATURE** _____
 64. **INITIALS** _____
 65. **REMARKS** _____
 66. **DATE** _____
 67. **TIME** _____
 68. **LOCATION** _____
 69. **REASON** _____
 70. **WITNESSES** _____
 71. **SIGNATURE** _____
 72. **INITIALS** _____
 73. **REMARKS** _____
 74. **DATE** _____
 75. **TIME** _____
 76. **LOCATION** _____
 77. **REASON** _____
 78. **WITNESSES** _____
 79. **SIGNATURE** _____
 80. **INITIALS** _____
 81. **REMARKS** _____
 82. **DATE** _____
 83. **TIME** _____
 84. **LOCATION** _____
 85. **REASON** _____
 86. **WITNESSES** _____
 87. **SIGNATURE** _____
 88. **INITIALS** _____
 89. **REMARKS** _____
 90. **DATE** _____
 91. **TIME** _____
 92. **LOCATION** _____
 93. **REASON** _____
 94. **WITNESSES** _____
 95. **SIGNATURE** _____
 96. **INITIALS** _____
 97. **REMARKS** _____
 98. **DATE** _____
 99. **TIME** _____
 100. **LOCATION** _____
 101. **REASON** _____
 102. **WITNESSES** _____
 103. **SIGNATURE** _____
 104. **INITIALS** _____
 105. **REMARKS** _____
 106. **DATE** _____
 107. **TIME** _____
 108. **LOCATION** _____
 109. **REASON** _____
 110. **WITNESSES** _____
 111. **SIGNATURE** _____
 112. **INITIALS** _____
 113. **REMARKS** _____
 114. **DATE** _____
 115. **TIME** _____
 116. **LOCATION** _____
 117. **REASON** _____
 118. **WITNESSES** _____
 119. **SIGNATURE** _____
 120. **INITIALS** _____
 121. **REMARKS** _____
 122. **DATE** _____
 123. **TIME** _____
 124. **LOCATION** _____
 125. **REASON** _____
 126. **WITNESSES** _____
 127. **SIGNATURE** _____
 128. **INITIALS** _____
 129. **REMARKS** _____
 130. **DATE** _____
 131. **TIME** _____
 132. **LOCATION** _____
 133. **REASON** _____
 134. **WITNESSES** _____
 135. **SIGNATURE** _____
 136. **INITIALS** _____
 137. **REMARKS** _____
 138. **DATE** _____
 139. **TIME** _____
 140. **LOCATION** _____
 141. **REASON** _____
 142. **WITNESSES** _____
 143. **SIGNATURE** _____
 144. **INITIALS** _____
 145. **REMARKS** _____
 146. **DATE** _____
 147. **TIME** _____
 148. **LOCATION** _____
 149. **REASON** _____
 150. **WITNESSES** _____
 151. **SIGNATURE** _____
 152. **INITIALS** _____
 153. **REMARKS** _____
 154. **DATE** _____
 155. **TIME** _____
 156. **LOCATION** _____
 157. **REASON** _____
 158. **WITNESSES** _____
 159. **SIGNATURE** _____
 160. **INITIALS** _____
 161. **REMARKS** _____
 162. **DATE** _____
 163. **TIME** _____
 164. **LOCATION** _____
 165. **REASON** _____
 166. **WITNESSES** _____
 167. **SIGNATURE** _____
 168. **INITIALS** _____
 169. **REMARKS** _____
 170. **DATE** _____
 171. **TIME** _____
 172. **LOCATION** _____
 173. **REASON** _____
 174. **WITNESSES** _____
 175. **SIGNATURE** _____
 176. **INITIALS** _____
 177. **REMARKS** _____
 178. **DATE** _____
 179. **TIME** _____
 180. **LOCATION** _____
 181. **REASON** _____
 182. **WITNESSES** _____
 183. **SIGNATURE** _____
 184. **INITIALS** _____
 185. **REMARKS** _____
 186. **DATE** _____
 187. **TIME** _____
 188. **LOCATION** _____
 189. **REASON** _____
 190. **WITNESSES** _____
 191. **SIGNATURE** _____
 192. **INITIALS** _____
 193. **REMARKS** _____
 194. **DATE** _____
 195. **TIME** _____
 196. **LOCATION** _____
 197. **REASON** _____
 198. **WITNESSES** _____
 199. **SIGNATURE** _____
 200. **INITIALS** _____
 201. **REMARKS** _____
 202. **DATE** _____
 203. **TIME** _____
 204. **LOCATION** _____
 205. **REASON** _____
 206. **WITNESSES** _____
 207. **SIGNATURE** _____
 208. **INITIALS** _____
 209. **REMARKS** _____
 210. **DATE** _____
 211. **TIME** _____
 212. **LOCATION** _____
 213. **REASON** _____
 214. **WITNESSES** _____
 215. **SIGNATURE** _____
 216. **INITIALS** _____
 217. **REMARKS** _____
 218. **DATE** _____
 219. **TIME** _____
 220. **LOCATION** _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <u>KEARNEY</u> First <u>M</u> Middle <u>M</u> Last <u>BOHN</u> | | | 2a. DATE OF DEATH
Month <u>MARCH</u> Day <u>8</u> Year <u>1968</u> | | | 2b. HOUR
<u>9:25</u> AM | | | | | |
| 3. SEX
<u>M</u> | | 4. RACE
<u>W</u> | | 5. DATE OF BIRTH
<u>6-10-1885</u> | | 6. AGE (In years last birthday)
<u>82</u> YRS. | | IF UNDER 1 YEAR
MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS.
HOURS <u></u> MIN. <u></u> | |
| 7a. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>BALTO. CO.</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>CATONSVILLE</u> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>SUMMIT HOME</u> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>MACH.</u> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>RAIL CO.</u> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>MD</u> | | | 13b. COUNTY
<u>BALTO. CATONSVILLE</u> | | 13c. CITY OR TOWN
<u>CATONSVILLE</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<u>17 NEWBURG AVE</u> | | |
| 14. FATHER'S NAME First <u>WM. BOHN</u> Middle <u></u> Last <u></u> | | | 15. MOTHER'S MAIDEN NAME First <u>LAURA SNYDER</u> Middle <u></u> Last <u></u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes (no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>173031574</u> | | 17. INFORMANT
<u>ETHEL V. SHEPARD</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>HEART BLOCK</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>ARTERIOSCLEROTIC HEART DIS.</u>
<u>3 YRS</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 MOS.</u>
<u>6 MOS.</u>
<u>3 YRS</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4200</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>10/65</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>PROSTATIC HYPERTROPHY</u> | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <u></u> Month <u></u> Day <u></u> Year <u>19</u>
P.M. <u></u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>67</u> , to <u>MAR 8</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>MAR 6</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>John N. Snyder MD</u> | | DEGREE <u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/8/68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>JOHN N. SNYDER</u> | | 22e. ADDRESS
<u>6348 FREDERICK RD</u> | | <u>CATONSVILLE MD 21228</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE
<u>3/11/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>FAIRMOUNT</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>LIBERTY TOWN MD.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>E. S. McNeil</u> | | | | ADDRESS
<u>Catonville MD</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 11 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

1. [Illegible text]

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03626

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03507

| | | | | | | | | | | | | | | | |
|---|---------|------------------|--|---|------|--|-----|---|--|--|----------|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| Martin Gregory Boone | | | | | | Mar. 16, 1968 | | | | | | M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | | |
| Male | White | Nov. 25, 1964 | 3 YRS. | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | 1968 | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | |
| Maryland | | | U. S. A. | | | | | | Baltimore | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Edgemere | | | 7306 Bay Front Road | | | None | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Baltimore | | | Edgemere | | | | | | 7306 Bay Front Road | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Grandmother) ADDRESS | | | |
| Carl Otter | | | Shirley J. Boone | | | None | | | | | | Dundalk, Md.
Mrs. Elsa L. Hubbard, 3223 Dundalk Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning - 890X</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>1st & 2nd Burns over lower Body</u> | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>9160</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Died in House Fire</u> | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u>Home</u> | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>7306 Bay Front Rd - Edgemere Baltimore</u> | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>MB Davis</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> 6800 Mornington Rd. | | | | 22b. DATE SIGNED | | | | | | | |
| EXAMINER'S NAME (Type) Melvin B. Davis | | | | M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | Mar. 16, 1968 | | | | | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ADDRESS (Street, city, town, or county) | | | | Dundalk, Md. 21222 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 3/19/68 | | | | Oak Lawn Cemetery | | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | | | MAR 26 1968 | | | | <u>Charles Judge</u> | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 03627 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03608 | | | |
|---|---------|------------------|--|--|---|--|--------------------------------|--|--------------------------|--|----------|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | | 20. DATE KNOWN OF DEATH MATED | | 2b. HOUR | |
| FLETA | | | MAY | | BOPP | | | | | | 12N | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| F | W | 5/26/91 | | 76 YRS. | | | | | Month 3 Day 31 Year 1968 | | 428 M | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| VA. | | | USA | | | | | | BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ESSEX | | | | 315 SO. TAYLOR AVE | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MD. | | | | BALTO. | | ESSEX | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 315 SO. TAYLOR AVE | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| FERDINAND LEFFEL | | | | | P | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT ADDRESS | | | |
| NO | | | | | | | | | | JAMES BOPP JR. ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4129 A-S-C-V-DISEASE
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | Vmp | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| 22b. DATE SIGNED | | | | | | | | | | | | | |
| ACTUAL SIGNATURE M. B. Davis | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | |
| EXAMINER'S NAME (Type) M-B Davis MD-6800M | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | |
| | | | | | ADDRESS (Street, city, town, or county) Baltimore-MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | 4/3/68 | | MEADOW RIDGE | | | BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| J.G. CONNELLY SONS | | | | | | | 300 MACE | | | APR 5 - 1968 | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | |
|--|--|--|--------------------------|--|-------------------|--|--|-----------------------------------|--|--|
| 03628 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | Items 1 & 14, telephone call 3/8/68 | | Funeral Home | | 03609 | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Philip | | | Brierley | | March 1, 1968 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| male | | white | | May 19, 1899 | | 68 | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| New Hampshr. | | U. S. | | | | Baltimore | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Catonsville | | SPRING GROVE STATE HOSP. | | Prof. in research | | Dept. of Agr. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md. | | Pr. Geo. | | Hyattsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 6405 Queens Chapel Rd. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Benjamin Brierley | | | Harriet Tarbuck | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| Yes | | W.W. I | | 217-44-0384 | | Records: SPRING GROVE STATE HOSPITAL | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Asphyxia | | | | | | | | | | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF Aspiration of food | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Chronic Brain Syndrome, Psychotic Reaction | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4500 Generalized Arteriosclerosis | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Feb. 13, 1967, to March 1, 1968, that (I) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | | | |
| Imre Kopits, M.D. | | | | 3-1-68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| (Anthony J. Young, M.D.) | | | | SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Removal | | 3/3/68 | | Ogallala Cemetery | | Ogallala Nebraska | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. RECORD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| The S.H. Hines Co. 2901-14th St NW Wash. D.C. | | | | MAR 8 1968 | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) HOWARD RANDOLPH BROLL | | | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 68 | | | 2b. HOUR
1:30 PM | |
| 3. SEX
M | | 4. RACE
Can. | | 5. DATE OF BIRTH
12-16-1896 | | 6. AGE (In years last birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
BALTO. MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTIMORE MEDICAL CENTRE | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Retired Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Banking | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
BALTO. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
LONG GREEN WASHINGTON HOTEL 115 E. MELROSE 5009 Ledestene Way 21206 Ave | |
| 14. FATHER'S NAME First Middle Last
CHARLES BROLL | | 15. MOTHER'S MAIDEN NAME First Middle Last
FRANCES LOUISE MORAN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown 168 (If yes give year or dates of service) WWI | | 16b. SOCIAL SECURITY NO.
217-14-1193 | | 17. INFORMANT Emma Nixon, Address SISTER-IN-LAW 3311 BATAVIA AVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) extensive myocardial infarct
410.9
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 9, 1968 , to MARCH 26 1968 , that (I) (we) last saw the deceased alive on MARCH 26 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
M. Isabelle Macgregor MD | | | | | | 22c. DATE SIGNED
3-26-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Isabelle Macgregor | | 22e. ADDRESS
G.B.M.C. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/29/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Buck, Inc. Balto. | | | | 25a. REC'D BY REGISTRAR
MAR 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | | |

W1250

65320

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03611

| | | | | | |
|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print)
RICHARD JESSE BROPHY | | | 2a. DATE OF DEATH
Month March Day 30 Year 1968 | | 2b. HOUR
8:00P M |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
SEPT 24, 1907 | | 6. AGE (In years lost birthday)
60 YRS. | IF UNDER 1 YEAR
MONTHS 0 DAYS 0
IF UNDER 24 HRS.
HOURS 0 MIN. 0 |
| 7a. BIRTHPLACE (State or foreign country)
BALTO, MD | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTIMORE | | Md. |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
PRESSMAN | | 12b. KIND OF BUSINESS OR INDUSTRY
NEWSPAPER |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | 13b. COUNTY
BALTIMORE | 13c. CITY OR TOWN
BALTIMORE | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
345 S SMALLWOOD STREET | |
| 14. FATHER'S NAME First Middle Last
JOHN BROPHY | | 15. MOTHER'S MAIDEN NAME First Middle Last
MARGARET RICE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service)
WW II | | 16b. SOCIAL SECURITY NO.
212 01 44 45 | | 17. INFORMANT Address
CLINICAL RECORDS, VA HOSP, FORT HOWARD, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5271
(b) Pulmonary Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 HOURS
YEARS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cor Pulmonale, Uremia | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that to (this hospital) attended the deceased from 3/23/68 , 19____, to 3/30/68 , 19____, that XX (we) lost saw the deceased alive on 3/30/68 , 19____, and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (we) did XXXXXX view the body after death. | | | | | |
| 22b. SIGNATURE
Richard R. Stephenson | | | | 22c. DATE SIGNED
3/30/68 | |
| 22d. PHYSICIAN'S NAME (Type)
RICHARD R. STEPHENSON, M.D. | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland | | | | | |
| 24. FUNERAL DIRECTOR
FREDERICK & SONS | | 25a. REC'D BY REGISTRAR
APR 1 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|------------------------------|--|--|--|---|--|---|--|--|------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR P. M. | | | |
| Gertrude E | | | Brower | | | March 21 1968 | | | 2:12 M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| female | | white | | June 22, 1885 | | | 82 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Brooklyn, N.Y. | | U.S.A. | | | | Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson 21204 | | | Dulaney Towson Nursing Home | | | Housewife | | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Baltimore | | Towson | | | | 504 Alabama Road | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Theodore Williams | | | Evelyn Hyde Brower | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| X None | | | | | Dulaney Towson Nursing Home, 111 West Road 21204 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 CORONARY THROMBOSIS
DUE TO, OR AS A CONSEQUENCE OF
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOSCLEROSIS GENERAL
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
2 years
10 years | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1954, to 3/21, 1968, that (I) (we) last saw the deceased alive on 3/21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | 22b. SIGNATURE Robert T. Parker M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 3/21/1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) ROBERT T. PARKER M.D. | | | 22e. ADDRESS SOUTH BALTO GENERAL HOSP 21230 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Removal Burial | | | Mar/25, 1968 | | Hurley Cemetery | | | Hurley, New York | | | | |
| 24. FUNERAL DIRECTOR John Burns' Sons | | | ADDRESS Towson Md | | | 25a. REC'D BY REGISTRAR DATE MAR 26 1968 | | | 25b. REGISTRAR'S SIGNATURE | | | |

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Sadie | | First L. | | Middle Brown | | Last Brown | | 2a. DATE OF DEATH
Month March Day 20 Year 1968 | | 2b. HOUR
M | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
7/3/1877 | | 6. AGE (In years last birthday)
90 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Shady Nook Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Howard | | 13c. CITY OR TOWN
Woodstock | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
rural | | | |
| 14. FATHER'S NAME
First George Middle Snyder Last Snyder | | 15. MOTHER'S MAIDEN NAME
First Mary S Middle Snyder Last Snyder | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
? | | 17. INFORMANT
Address
W. Howard Brown Woodstock, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio respiratory failure
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Advanced arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) stages pneumonia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4500 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1967 to 20 March 1968 , that (I) (we) last saw the deceased alive on 20 March 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William S. Bryson M.D. | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
22 March 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
William S. BRYSON | | 22e. ADDRESS
4605 Edmondson Ave | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-23-68 | | 23c. NAME OF CEMETERY OR CREMATORY
MT VIEW | | 23d. LOCATION (City or Town) (County) (State)
ALPHA Howard Md. | | | | | |
| 24. FUNERAL DIRECTOR
Higginbotham-Slack | | ADDRESS
Elmwood City, Md. | | 25a. REC'D BY REGISTRAR
DATE
MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE
James J. ... | | | | | |

03632

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03618

41386

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

03633

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03614

| | | | | | | | | |
|---|---------------------|---|---------------------|---|--|---|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First
<i>Gertrude</i> | Middle
<i>A.</i> | Last
<i>Buchman</i> | 2a. DATE KNOWN OF DEATH
Month <i>March</i> Day <i>21</i> Year <i>1985</i> | | 2b. HOUR
<i>5:30</i> M | |
| 3. SEX
<i>F</i> | 4. RACE
<i>W</i> | 5. DATE OF BIRTH
<i>4/6/1903</i> | | 6. AGE (In years last birthday)
<i>64</i> YRS. | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN. | 2c. DATE PRONOUNCED DEAD
Month <i>March</i> Day <i>21</i> Year <i>1985</i> | 2d. HOUR
<i>5:30</i> M |
| 7a. BIRTHPLACE (State or foreign country)
<i>Cumberland Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S. A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> | | Md. |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>St. Joseph's Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Beautician</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Beauty</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>BALTIMORE</i> | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>421 Venable Ave.</i> |
| 14. FATHER'S NAME
<i>Peter H. Mause</i> | | 15. MOTHER'S MAIDEN NAME
<i>Mary Ellen Kerns</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>220-30-7413</i> | | 17. INFORMANT
<i>Miss Juanita Mause</i> | | ADDRESS
<i>(Same)</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4109</i>
(b) <i>Coronary Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>1/yr</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>Sudden</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>4201</i> | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
<i>Charles F. O'Donnell</i> | | EXAMINER'S NAME (Type)
<i>Charles F. O'Donnell</i> | | M.D. | | 22b. DATE SIGNED
<i>3/21/68</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/25/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Moreland Mem. Park</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Parkville, Balto. Co., Md.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Henry W. Jenkins & Sons Co.</i> | | ADDRESS
<i>4905 York Road Balto. 12, Md.</i> | | 25a. *RECD BY REGISTRAR
DATE
<i>MAR 26 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. ...</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03634 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03615 | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|--|--|-----------------------------------|--------|------------------|------|----|
| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | | |
| CLARA | | | | CLEVELAND | BUCKLER | March | Month | 20 | Day | 68 | Year | 1:30 | PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Female | | Cau. | | October 5th, 1884 | | | 83 | | MONTHS | | DAYS | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Wicomico Co. Md. | | USA | | | | Baltimore Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Baltimore | | | Greater Balto. Med. Center | | | Homemaker | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Md. | | | | | Balto. | | | | 5913 Glenkirk Rd. | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | | |
| John Alex. Insley | | | | | | Klara V. Roberts | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | |
| no | | | | | | Mr. Edw StClara Burekler | | | 609 Hampton Lane - 04 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 443x | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21, 19 68, to 3/20, 19 68, that (I) (we) last saw the deceased alive on 3/20, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | | | | | |
| [Signature] | | | March 20, 1968 | | | RUDIGER BREITENECKER, M.D. | | | | | | | |
| 22e. ADDRESS | | | 22f. ADDRESS | | | | | | | | | | |
| | | | Greater Baltimore Medical Center | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | 3/23/68 | | Mt. Zion M.E. Church Cem. | | | St. Marys Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| [Signature] | | | DATE | | | [Signature] | | | | | | | |

21020

OFFICE OF THE

03630

DATE: 10/10/1964

TO: Mr. J. Edgar Hoover

FROM: Mr. [illegible]

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-68

| 03635 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03616 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Henry W. Buddemeier | | | | | | | | | | Month 3 Day 23 Year 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH October 1, 1886 | | | | | | | | | | 6. AGE (In years last birthday) 81 YRS. | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Baltimore Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Anneslie | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 525 Murdock Rd. | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY County gov, T | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | | | | | | | 13b. CITY Baltimore | | | | | | | | | | 13c. CITY OR TOWN Anneslie | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 525 Murdock Rd. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Frederick Buddemeier | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last unknown | | | | | | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | | | | | | | | | | 16b. SOCIAL SECURITY NO. 215 03 4637 A | | | | | | | | | | 17. INFORMANT Address Lydia M. Buddemeier 525 Murdock Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X Carcinoma of esophagus with metastases | | | | | | | | | | 1 year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 150X | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | 150X None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from September, 1967, to March 23, 1968, that (H) (we) lost saw the deceased alive on 3/18/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE L. Myrton Gaines Jr. MD DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 3/26/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) L. Myrton Gaines Jr. | | | | | | | | | | 22e. ADDRESS 7800 York Rd. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 3/27/1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Baltimore Md. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE MAR 28 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
30M REV. 1-68

03636

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03617

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Mary B. Buddemeier | | | 2a. DATE OF DEATH
Month 3 Day 2 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
August 18, 1885 | | 6. AGE (In years lost birthday)
82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Holly Hill Manor | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Anneslie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
628 Murdock Rd. | | 14. FATHER'S NAME
First John Middle Beynon Last Margaret | | 15. MOTHER'S MAIDEN NAME
First Margaret Middle Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217 01 5212 D | | 17. INFORMANT
John Buddemeier | | Address
628 Murdock Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Decompensative Cardio Vascular Disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 20, 1968 , to March 2, 1968 , that (I) (we) last saw the deceased alive on 3/2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lawrence C. Post | | DEGREE
MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/4/68 | |
| 22d. PHYSICIAN'S NAME (Type)
LAURENCE C. POST | | 22e. ADDRESS
6805 York Rd - Baltimore 21212 Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/5/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
Mitchell- Wiedefeld Home | | ADDRESS
6500 York Rd. | | 25a. REC'D BY REGISTRAR
DATE MAR 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

03617

OFFICE OF THE

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John F. Kennedy

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03637

CERTIFICATE OF DEATH

03615

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| | | | | | | | |
|---|------------------------------|---|--|--|---|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Baltimore MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | c. LENGTH OF STAY IN 1b
13 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Mercy Villa Nursing Home | | | | d. STREET ADDRESS
300A East University Pkwy. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Sarah (Sally) D. Butke | | | | 4. DATE OF DEATH
Month March Day 25 Year 68 | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Oct. 20, 1876 | | 9. AGE (In years last birthday)
91 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Baltimore | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
B.F. Curry | | | | 14. MOTHER'S MAIDEN NAME
Mary Mooney | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
yes | | 17. INFORMANT Address
Sister M. Carlotta, R.S.M. 6400 Bellona Ave. Mercy Villa | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO (b) sw. years
DUE TO (c) sw. years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
4221 | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1959 , to 3-25, 1968 , that (I) (we) last saw the deceased alive on 2-24, 1968 , and that death occurred at 11:30 AM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Alfred G. Ossman Jr. M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
3-25-68 | |
| 22c. PHYSICIAN'S NAME (Type)
Alfred G. Ossman Jr. M.D. | | | | 22d. ADDRESS
1101 St Paul St. Balto 2 Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
3/28/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery Baltimore, Md. | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR
John A. Moran, Inc. 3000 E. Baltimore Street | | | | 25a. REC'D BY REGISTRAR
Charles Judge | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MAR 29 1968

02581

STATE OF CALIFORNIA

02581

Baltimore

Baltimore

Baltimore

Baltimore

Baltimore

15 months

George William Harrison Howe

300A East University Hwy.

Calif

Calif

Calif

Oct. 22, 1978

Baltimore

R.F. Curry

Mary Murray

George William

1010 N. Carroll, R.F.D. 1, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03638

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03619

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
Mary Brigid Byrne | | | 2a. DATE OF DEATH
Month Day Year
3 2 68 | | | 2b. HOUR
9:50 AM | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
6/5 1874 | | 6. AGE (In years last birthday)
93 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Ireland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Stella Maris Hospice | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Child's nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1625 Park Heights Ave. | |
| 14. FATHER'S NAME
First Middle Last
Patrick Byrne | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Catherine Tierney | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO.
217-30-1989 | | 17. INFORMANT
Hospice records Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CVA
4/29 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Asen's
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/5/67 , 19__, to 3/2/68 , 19__, that (I) (we) last saw the deceased alive on 3/2/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert J. Mahon DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/2/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert J. Mahon, M.D. | | | | 22e. ADDRESS
204 E. Joppa Rd. Towson | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
Mar. 5, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, 1050 York Road
Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 5 1968 | | 25b. REGISTRAR'S SIGNATURE
John Judge | |

MEDICAL CERTIFICATION

01000

ALABAMA STATE DEPT. OF REVENUE

00000

00000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03639 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|--|---|---|--|--|---|---|--|--|--|--|----------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | 03620 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) EDGAR | | | | | First Middle Last
BYRON | | | | | 2a. DATE OF DEATH
Month MARCH Day 2 Year 1968 | | | | | 2b. HOUR
2:00P M | | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
8/25/90 | | | 6. AGE (In years last birthday)
77 YRS. | | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
RETAIL SALESMAN | | | 12b. KIND OF BUSINESS OR INDUSTRY
PLUMBING | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
808 W. BARRE STREET | | | | | | | |
| 14. FATHER'S NAME First Middle Last
CHARLES - - BYRON | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
JOSEPHINE - - HAMILTON | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES (If yes give war or dates of service)
WWI | | | 16b. SOCIAL SECURITY NO.
212 18 37 96 | | | 17. INFORMANT Address
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA, BI-LATERAL, UNKNOWN ORGANISM
450X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 465X
(b) - -
DUE TO, OR AS A CONSEQUENCE OF
(c) PULMONARY INFARCTION, LEFT
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DAYS | | | | | |
| | | | | | | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
PULMONARY EMPHYSEMA, BI-LATERAL PULMONARY TUBERCULOSIS, INACTIVE | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that it (this hospital) attended the deceased from FEB 21 , 19 68 , to MAR 2 , 19 68 , that it (we) last saw the deceased alive on MAR 2 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did) obtain view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Neilson Neilson, MD DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | | | 22c. DATE SIGNED
3-3-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) NEILSON, NEILON | | | | | | | | | | | | | | 22e. ADDRESS
VAH, FORT HOWARD, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3/6/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL CEM. | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
COWAN FUNERAL HOME ADDRESS
POPLIN & HOLLAND STS. BALTIMORE, MARYLAND 23, MD | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 5 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-1
30M REV. 7/68

03640

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03621

| | | | | | |
|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
George Gordon Cadle | | | 2a. DATE OF DEATH
Month Day Year
March 1, 1968 | | 2b. HOUR
7:25 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
10/23/06 | | 6. AGE (In years lost birthday)
61 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Baltimore Catonsville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hospt. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Sheet metal worker | 12b. KIND OF BUSINESS OR INDUSTRY
Martin Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
- | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
606 Scott Street ST. | |
| 14. FATHER'S NAME First Middle Last
George A. Cadle | | 15. MOTHER'S MAIDEN NAME First Middle Last
May Anderson | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT Address
Records: Spring Grove State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic coma
5710
DUE TO, OR AS A CONSEQUENCE OF
(b) Laennec's Cirrhosis
DUE TO, OR AS A CONSEQUENCE OF
(c) Hepatitis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5811 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (this hospital) attended the deceased from Sept. 2, 1964 , to March 1, 1968 , that (I) (we) last saw the deceased alive on March 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE
Anthony J. Young, M.D. | | | | 22c. DATE SIGNED
2-1-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Anthony J. Young, M.D. | | | | 22e. ADDRESS
Spring Grove State Hospital | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
3/4/68 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cem. | 23d. LOCATION (City or Town) (County) (State)
Ritchie Hwy Md. | | |
| 24. FUNERAL DIRECTOR
John J. Conan & Son Inc. | | 25a. REC'D BY REGISTRAR
W. Hollis St. | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 5-63

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 03641 | | | | | | 03622 | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Balto.</i> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
a. STATE <i>MD.</i> b. COUNTY <i>BALTIMORE</i> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Glen Arm</i> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - GLEN ARM</i> | | | | | |
| c. LENGTH OF STAY IN 1b <i>6 YRS.</i> | | | | | | d. STREET ADDRESS <i>SHARON DRIVE, P.D.#1 Box 587</i> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>SHARON DRIVE, P.D.#1 Box 587</i> | | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <i>EVA</i> Middle <i>B.(C.)</i> Last <i>CALWELL</i> | | | | | | 4. DATE OF DEATH Month <i>MAR.</i> Day <i>25</i> Year <i>1968</i> | | | | | |
| 5. SEX <i>FEMALE</i> | | 6. COLOR OR RACE <i>WHITE</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <i>Nov. 21, 1897</i> | | 9. AGE (In years last birthday) <i>70</i> yrs. | | IF UNDER 1 YEAR Months <i></i> Days <i></i> IF UNDER 24 HRS. Hours <i></i> Min. <i></i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Typist</i> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Edgewood ARSENAL MD</i> | | | | 11. BIRTHPLACE (County & State, or foreign country) <i>U.S.A.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>GEORGE FINNEY BOWMAN</i> | | | | | | 14. MOTHER'S MAIDEN NAME <i>EMMA NORRIS</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16. SOCIAL SECURITY NO. <i>214-12-2803</i> | | 17. INFORMANT <i>Mrs. Dorothy W. Hoffman</i> | | Address <i>SHARON, DR. #1057 GLEN ARM, MD.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129</i> DUE TO <i>Stoke's Adams Syndrome</i> (b) <i>Arteriosclerotic Cardio-Vascular Disease</i> (c) <i>Sudden</i> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>4221</i> | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year <i>Jan 19</i> Hour a.m. <i></i> p.m. <i></i> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <i>Home</i> | | 20f. (City or town) <i>Mar</i> (County) <i></i> (State) <i></i> | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1968</i> to <i>Mar 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 1968</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>F.T. KASIK JR</i> | | | | | | 22b. DATE SIGNED <i>3/26/68</i> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <i>F.T. KASIK JR</i> | | | | | | 22d. ADDRESS <i>9005 HARFORD Rd BALTO</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i> | | | | 23b. DATE THEREOF <i>APRIL, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>LONDON PARK CEM.</i> | | 23d. LOCATION (City, town or county) <i>BALTIMORE</i> | | (State) <i>MD.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>R. Madison Mitchell, Harford Co., Md.</i> | | | | | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | DATE <i>MAR 29, 1968</i> | |

03682

03681

Atchafalaya
Interpretive Center

F.T. KASIR JR
Jr
from the front of the
door HAROLD Rd. Baito

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03622

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|-------------------------------------|--|--|--|----------------------|--|--|--|--|--|-----------------|--|--|--|
| 1. DECEASED NAME
(Type or print) | | First
<i>Lee</i> | | Middle
<i>V.</i> | | Last
<i>Cariello</i> | | 2a. DATE OF DEATH
Month
<i>March</i> | | Day
<i>30</i> | | Year
<i>68</i> | | 2b. HOUR
<i>N</i> | | | | | | | | | |
| 3. SEX
<i>F.</i> | | 4. RACE
<i>W.</i> | | 5. DATE OF BIRTH
<i>FEB. 14, 1899</i> | | 6. AGE (In years last birthday)
<i>69</i> YRS. | | IF UNDER 1 YEAR
MONTHS
<i></i> | | IF UNDER 24 HRS.
DAYS
<i></i> | | HOURS
<i></i> | | MIN.
<i></i> | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>NEW YORK</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>BALTIMORE CO.</i> | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>TOWSON</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>CHESTERPEAKE MANOR</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>HOUSEKEEPER</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>HOME</i> | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>MD.</i> | | 13b. COUNTY
<i>BALTO.</i> | | 13c. CITY OR TOWN
<i>RANDALLMAN</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>3712 SONORA RD.</i> | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First
<i>JOHN</i> | | | | Middle
<i>VENUSSI</i> | | | | Last
<i></i> | | | | 15. MOTHER'S MAIDEN NAME First
<i>ALETHEA</i> | | | | Middle
<i>BUFF</i> | | | | Last
<i></i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
<i>NO</i> | | | | 16b. SOCIAL SECURITY NO.
<i></i> | | | | 17. INFORMANT
<i>Luigi Cariello - 3712 Sonora Rd.</i> | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 1621 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <i>Coronary artery disease</i> | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | |
| (c) <i>Extension of lower BT</i> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | |
| 1621 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Alberto Nannini</i> for Dr. J. H. Hirschfeld. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | | 22c. DATE SIGNED <i>3.30.68</i> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>ALBERTO NANNINI</i> | | | | | | | | | | | | | | | | 22e. ADDRESS <i>6919 Hayford Rd.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE <i>4-2-68</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville Md.</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <i>John Carrington B.H. Cottrill</i> ADDRESS <i>1000 N. ...</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 25a. REGISTRATION NUMBER <i>1968</i> REGISTRAR'S SIGNATURE <i>John Carrington</i> | | | | | | | | | | | | | | | | | | | | | | | |

2526

32650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 7 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

William Newcomer

03643

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03624

| | | | | | |
|--|--|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) VINCENT LEO CAVANAUGH | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 68 | | 2b. HOUR
5:30 AM |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
8.23.1905 | | 6. AGE (In years
last birthday)
62 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore County Md. | | |
| 10. CITY OR TOWN OF DEATH
Mt. Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) Mt. Wilson State Hosp. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) Painter | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
416 N. Greene Str. |
| 14. FATHER'S NAME First Middle Last
JAMES CAVANAUGH | | 15. MOTHER'S MAIDEN NAME First Middle Last
ALMA HOWARD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) None | | 16b. SOCIAL SECURITY NO.
218-10-1900 | | 17. INFORMANT
Address
Records, Mt. Wilson State Hospital | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA OF LUNG
1621
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. 163X
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 years |
| PART 2. OTHER-SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Arteriosclerotic heart disease PULMONARY TUBERCULOSIS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7.6.1967 , to 3.26.1968 , that (I) (we) last
saw the deceased alive on 3.26.1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
W Newcomer | | | | 22c. DATE SIGNED
3.26.1968 | |
| 22d. PHYSICIAN'S
NAME (Type) William Newcomer, M.D. | | | | 22e. ADDRESS
Mount Wilson, Maryland | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
burial | | 23b. DATE
3/28/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | |
| 23d. LOCATION (City or Town)
Brooklyn R.F.D. Md. | | (County) (State) | | | |
| 24. FUNERAL DIRECTOR
Singleton Funeral Home | | ADDRESS
Glen Burnie, Md. | | 25a. REC'D BY REGISTRAR
DATE APR 1 - 1968 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | |

4320

1

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>03644</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>02525</div> | | | | | | | | | | | |
|---|--|--|--|--|---|--|--|--|--|---|-----------------------------|
| 1. DECEASED-NAME (Type or print) <i>Cecelia E. Chase</i> | | | | | | 2a. DATE OF DEATH Month <i>March</i> Day <i>5</i> Year <i>68</i> | | | 2b. HOUR <i>7:30 AM</i> | | |
| 3. SEX <i>F.</i> | | 4. RACE <i>W.</i> | | 5. DATE OF BIRTH <i>April 2 - 1899</i> | | | 6. AGE (In years last birthday) <i>68</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) <i>Balto.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Balto. Co.</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Overlea</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>528 Dale Ave</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>At Home</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Balto</i> | | 13c. CITY OR TOWN <i>Overlea</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>528 Dale Ave</i> | | |
| 14. FATHER'S NAME First <i>George</i> Middle <i>Brady</i> Last <i>Spencer</i> | | | | 15. MOTHER'S MARDEN NAME First <i>Catherine</i> Middle <i>Spencer</i> Last <i>Spencer</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <i>220-40-8315</i> | | 17. INFORMANT <i>Harry T. Chase</i> | | | Address <i>528 Dale Ave</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i>
<i>4319</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cerebro Vascular disease</i>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>uncertain</i>
" | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>331X</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 <i>9/21</i> P.M. <i>1968</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>9/21</i> , 19 <i>68</i> , to <i>3/5</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>9/18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Paul G. Mueller M.D.</i> DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE, SIGNED <i>3/5/68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>PAUL G. MUELLER M.D.</i> | | | | | | 22e. ADDRESS <i>6411 BELAIR RD. BALTO. MD</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <i>BURIAL</i> | | | 23b. DATE <i>MAR 8 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>SACRED HEART CEMETERY</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>GERMAN HILL RD BALTO MD</i> | | | |
| 24. FUNERAL DIRECTOR <i>THE DIPPEC BROS INC</i> ADDRESS <i>7110 BELAIR RD</i> | | | | | | 25a. REC'D BY REGISTRAR <i>DATE MAR 7 1968</i> | | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i> | | |

03622

03624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03645

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03626

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) DAVID J. CLARKE | | | 2a. DATE OF DEATH
Month 3 Day 21 Year 1968 | | | 2b. HOUR 2:00 P M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
DEC. 28, 1941 | | 6. AGE (In years lost birthday)
26 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Baltimore Co. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1111 Overbrook Rd. 12 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
DRAFTSMAN - FRANK S. KLEIN & SONS | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
2616 E. Northern Pkwy. | | 14. FATHER'S NAME First Middle Last
Harry M. Clarke | | 15. MOTHER'S MAIDEN NAME First Middle Last
ISABEL A. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Mrs. Stephanie A. Wiedefeld-2616 Northern Pkwy. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Homologous Serum Hepatitis
39779
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic (valvular) rheumatic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) open heart surgery performed 3 months ago
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 wk. ? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
416 Congestive Heart Failure & left vent. hypertrophy & myocardial ischemia | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from October, 1959 , to March, 1968 , that (I) (last) saw the deceased alive on 3/6 19 68 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Robert W. Gebhardt M.D. DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/22/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Robert Gebhardt M.D. | | | | | | 22e. ADDRESS
1211 Northern Pkwy. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/25/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood | | 23d. LOCATION (City or Town) (County) (State)
Balto. Co. | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home-6500 York Rd-21212 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>03646</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03627</div> | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
Goldie | | | Middle
May | | | Last
COFIELL | | | 2a. DATE OF DEATH
Month
March Day
12 , Year
1968 | | | 2b. HOUR
8:15 AM | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
August 5, 1893 | | | 6. AGE (In years lost birthday)
74 YRS. | | | IF UNDER 1 YEAR
MONTHS
74 DAYS
74 HOURS
15 MIN. | | | IF UNDER 24 HRS.
HOURS
15 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
BALTO | | | 13c. CITY OR TOWN
Sparks | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Belfast Ave. | | | | | |
| 14. FATHER'S NAME First
John | | | Middle
A. | | | Last
Lloyd | | | 15. MOTHER'S MAIDEN NAME First
Bertie | | | Middle
Brown | | | Last
Brown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
213-36-9289 | | | 17. INFORMANT
Mr. Clarence L. Cofield | | | Address
Reisterstown, Md | | | | | | | | |
| 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that Dr. (this hospital) attended the deceased from 3/7/ , 19 68 , to 3/12/ , 19 68 , that (X) (we) last saw the deceased alive on 3/12/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Victoria Escobar | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
March 12, 1968 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Victoria Escobar, M.D. | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3/16/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore County, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons Reisterstown, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1514
30M REV. 7-68

1M

03647

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03628

| | | | | | | | | | |
|--|--|--|--------|---|--------------------------|--|----------|---|--------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| CHARLES | | | | COHEN | MARCH 26, 1968 | | 6 A.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. |
| MALE | | WHITE | | JUNE 8, 1906 | | 61 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| RUSSIA | | U.S.A. | | | | BALTIMORE | | ACME PAPER SUPPLY | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | 6980 MARSUE DR., APT. 2C | | SALESMAN | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | BALTIMORE | | | | | | 6980 MARSUE DR., APT. 2C | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| MORRIS | | | | COHEN | JENNIE | | | | ? |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | | MRS. ANNA COHEN | | 6980 MARSUE DR., APT. 2C | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
<u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sudden</u> | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| | | | | 523 | | 3/26 | | 68 | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5/23</u> , 19 <u>67</u> , to <u>3/26</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>3/11/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | |
| <u>Milton Kirsh</u> | | | | MILTON KIRSH | | 4000 W. NORTHERN PKWY. | | <u>[Signature]</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 3-27-68 | | KKNESSETH ISRAEL KOLK WOLYN | | BALTIMORE MD. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN | | RD | | DAN | | 27 1968 | | <u>[Signature]</u> | |

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CHARLES CONER MARCH 24 1948 8 47

MAIL WHITE 1948 8 47

RUSSIA U.S.A. BALTIMORE

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HARRIS ON APR 12 BALTIMORE

CONER WHITE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5-14
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
Joan Darlene Coleman | | | | | 2a. DATE OF DEATH
Mar 30 68ay Year | | 2b. HOUR
5:30 PM | | |
| 3. SEX
Female | | 4. RACE
Negro | | 5. DATE OF BIRTH
7-8-53 | | 6. AGE (In years last birthday)
14 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
by birth | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Child | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Child | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
- | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4810 Palmer Ave. | |
| 14. FATHER'S NAME First Middle Last
James Coleman | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Geraldine (Slaughter) Thomas | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
no | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Rosewood records | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia Subacute Bacterial</u>
3331
DUE TO, OR AS A CONSEQUENCE OF <u>Endocarditis (Possible)</u>
(b) <u>Congenital Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF <u>Metachromatic Leukodystrophy</u>
(c) <u>Metachromatic Leukodystrophy</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
7441 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>Mar. 24, 1966</u> , to <u>Mar. 30, 1968</u> , that (H) (we) last saw the deceased alive on <u>Mar. 30, 1968</u> , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Lucrecia F. Joven, M.D. | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-30-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Lucrecia F. Joven, M.D. | | | | | 22e. ADDRESS
Rosewood State Hosp. Owings Mills Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore Nat'l Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md | | | |
| 24. FUNERAL DIRECTOR
MORTON + Dyett 1701 LAURENS ST. | | | | | 25a. REC'D BY REGISTRAR
DATE APR 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03649

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03630

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|---------|------------------------------|--|---|--|---|--|---|--|----------------------------|--|---|--|---------------------------|--|----------------------------|--|--|--|-------|--|--|--|
| 1. DECEASED NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | | | | 2b. HOUR | | | | | | | | | | | |
| NOAH | | | | | | COLLINS, SR. | | 3- 2- 68 | | | | M | | | | | | | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | 2d. HOUR | | | | | | | | | |
| Male | Negro | 7-12-1894 | | 73 YRS. | | MONTHS | | DAYS | | Month 3- Day 2- Year 68 19 | | | | M | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | 10. CITY OR TOWN OF DEATH | | | | | | | | | |
| Halifax Co., Va. | | U.S.A. | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Dundalk | | | | | | | | Md. | | | | | | | | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Sparrows Point | | | | 819 I Street | | | | Watchman | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER | | | | | | | |
| Md. | | | | Sparrows Point | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 819 I Street | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | |
| Lindsay | | | | Collins | | | | Sallie | | | | Collins | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | | | | | | | | | |
| | | | | 213-09-1975 | | | | Mrs. Nettie Collins | | | | 819 I. Street | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>151X</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. | | | | City or Town | | | | County | | | | State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Theo. C. Anderson</u> | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED <u>3/4/68</u> | | | | | | | | | | | |
| EXAMINER'S NAME (Type) <u>THEO. C. ANDERSON</u> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | |
| Burial | | | | 3-5-68 | | | | Balto. Nat'l Cem. | | | | Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| MORTON & DYETT F.H. | | | | | | | | 1701 Laurens St. | | | | DATE MAR 5 1968 | | | | <u>J. Charles Judge</u> | | | | | | | |

WASHINGTON, D. C.

MAY 11 1933

TO THE SECRETARY OF AGRICULTURE

FROM THE DIRECTOR OF THE BUREAU OF PLANT INDUSTRY

SUBJECT: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

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[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 03631 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lutherville</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>1 Cavan Drive</u> | | | | | d. STREET ADDRESS
<u>1 Cavan Drive</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Jeanette</u> Middle <u>D.</u> Last <u>Comstock</u> | | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>17</u> Year <u>1968</u> | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Feb. 15, 1889</u> | | 9. AGE (In years last birthday)
<u>79</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>New York</u> | | | 12. CITIZEN OF WHAT COUNTRY
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>unknown de'd</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>unknown dec'd</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | | 16. SOCIAL SECURITY NO.
<u>none</u> | | 17. INFORMANT
<u>Family records</u> Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
<u>410.9</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u>
DUE TO (c) <u>10 yrs</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 min</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>4201</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1958</u> to <u>March 17, 1968</u> that (II) (we) last saw the deceased alive on <u>March 17, 1968</u> and that death occurred at <u>1:30 PM</u> , from causes on and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Georget. Guilman</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>March 18, 1968</u> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/20/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore BALD.</u> | | |
| 24. FUNERAL DIRECTOR
<u>John Burns Sons</u> ADDRESS <u>Loudon</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 21 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

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OFFICE OF THE

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

March 1911

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M REV. 7-68

| 03651 | | | | | | | | | | | | 03632 | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|---|--|--|--|--------------------------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | First
Mary | | | | Middle
Alice | | | | Last
Connors | | | | 2a. DATE OF DEATH
Month 3 Day 22 Year 68 | | | | 2b. HOUR
4 A M | | | |
| 3. SEX
Female | | | | 4. RACE
Caucasian | | | | 5. DATE OF BIRTH
Nov. 9, 1922 | | | | 6. AGE (In years
last birthday)
45 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Baltimore | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Greater Balto. Med. Center | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Sales-lady | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Store | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | | | 13c. CITY OR TOWN
Millersville | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
817 Oakdale Circle | | | | | | | |
| 14. FATHER'S NAME First
Walter | | | | Middle
Henderson | | | | Last
Henderson | | | | 15. MOTHER'S MAIDEN NAME First
(UNKNOWN) | | | | Middle
(UNKNOWN) | | | | Last
(UNKNOWN) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)
None | | | | 16b. SOCIAL SECURITY NO.
214-14-8448 | | | | 17. INFORMANT
Mr. Joseph J. Connors (husband) Same as 13 | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Metastases of pancreatic carcinoma</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>1579</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>157x</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH?
Yes | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-11</u> , 19 <u>68</u> , to <u>3/22</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>3/22</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Rudiger Breitenecker</i> | | | | | | | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
3/22/68 | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) Rudiger Breitenecker, M.D. | | | | | | | | | | | | 22e. ADDRESS
6701 N. Charles St. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | | 23b. DATE
March 25, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Memorial Pk. | | | | 23d. LOCATION (City or Town) (County) (State)
Glen Burnie, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
R. P. Ware | | | | ADDRESS
Singleton Funeral Home Glen Burnie, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1968 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--------------------------------|-----------------------------|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
WALTER | | Middle
SCOTT | | Last
COOK | | 2a. DATE OF DEATH
March 18 Day 1968 | | 2b. HOUR
1:30 P | | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
March 19, 1902 | | | 6. AGE (In years
last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Penna. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore County Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
? Riderwood | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
8120 Thornton Rd. | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Ret. Bus. Mgr. McDonogh School | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
nr Towson | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
8120 Thornton Road | | | | |
| 14. FATHER'S NAME
First Middle Last
WALTER SCOTT COOK (Sr.) | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Helen ROWLETT | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
212-32-04424 | | | 17. INFORMANT: wife
Address 21204
Mrs. Clara Boyd Cook, 8120 Thornton Rd. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 min.
6 years | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Apr. 1, 1962, to Mar. 18, 1968, that (I) (we) last saw the deceased alive on Feb. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John M. Scott | | | M.D. DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-19-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
John M. Scott | | | 22e. ADDRESS
600 W. Belvedere Ave., Balto. Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
Mar. 21, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
Stewart & Mowen Co. 108 W. North Av., Balto. 1 | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE MAR 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

W.K. Adams, M.D.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
|--|---------|--|--|---|---|--|--|--|
| THEODORE ROOSEVELT COOPER | | | | | MARCH 24/68 | | 9:35 A.M. | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | |
| MALE | NEGRO | | 5/22/11 | | 66 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| MARYLAND | | U.S.A. | | | | Baltimore County, Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Mt. Wilson | | | Mt. Wilson State Hospital | | | LABORER | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | |
| MARYLAND | | | CHARLES | | NEWBURG | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | BOX 54 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | 16. SOCIAL SECURITY NO. | | | |
| JOSEPH COOPER | | | MARTHA | | 217-18-2443 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| UNKNOWN | | | 217-18-2443 | | SILERS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> | | | | | | | | 4 months |
| 157.9 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of Body of Pancreas</u> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(c) _____ | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 157X Far Advanced Pulmonary Tuberculosis | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>je</u> | |
| | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/20</u> , 19 <u>68</u> , to <u>3/24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | |
| <i>W. Newcomer</i> | | 3/24/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| William Newcomer, M.D. | | Mount Wilson, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | March 27/68 | | Shiloh Community Ch. Cem. | | Newburg, Ch. Co. Md. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Martell Adams Aquasco, Md. | | | | DATE APR 24 1968 | | <i>Charles Judge</i> | | |

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UNITED STATES DEPARTMENT OF THE INTERIOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03635

| | | | | | | | | | | | |
|--|--|---|---|---|---|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Joseph Bray Corcoran JR | | | 2a. DATE OF DEATH
Month 3 Day 10 Year 68 | | | 2b. HOUR
9 P. M. | | | | | |
| 3. SEX
male | | 4. RACE
Can | | 5. DATE OF BIRTH
6-30-25 | | 6. AGE (In years last birthday)
42 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
G.B.M.C. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Editorial Artist | | | 12b. KIND OF BUSINESS OR INDUSTRY
Newspaper | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md | | | 13b. COUNTY
Baltimore | | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1324 Walker Ave | | | |
| 14. FATHER'S NAME
First Joseph Middle B Last Corcoran | | | 15. MOTHER'S MAIDEN NAME
First Delores Middle Sweeney Last Sweeney | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give year or dates of service)
Yes 10-4-43 8-24-46 | | | 16b. SOCIAL SECURITY NO.
220-14-6913 | | | 17. INFORMANT
G.B.M.C. information street | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory failure
203X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Multiple myeloma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
203X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2.5 , 19 68 , to 3.10 , 19 68 , that (I) (we) last saw the deceased alive on 3.10 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dipak K. Mallik | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/10/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
DIPAK K. MALLIK. | | | | | | 22e. ADDRESS
G.B.M.C. | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | | 23b. DATE
3-14-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Louson Park Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR
Wm. E. Johnson | | | | | | ADDRESS
8521 Loch Raven Blvd, Balto. Md. | | 25a. REC'D BY REGISTRAR
DATE
MAR 14 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

03550

03550

Joseph B. Gorman
Male
USA
Baltimore

G.B.M.C. Editorial Artist
Baltimore x 1354 Walker Ave
Joseph B. Gorman
Baltimore x 1354 Walker Ave
G.B.M.C. Information Sheet

Joseph B. Gorman
Baltimore x 1354 Walker Ave
G.B.M.C. Information Sheet

Joseph B. Gorman
Baltimore x 1354 Walker Ave
G.B.M.C. Information Sheet

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Baltimore x 1354 Walker Ave
G.B.M.C. Information Sheet

Joseph B. Gorman
Baltimore x 1354 Walker Ave
G.B.M.C. Information Sheet

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|-------------------|--|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Kenneth K. Cornwell | | | | | | Month 3 Day 19 Year 68 | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| Male | | White | | 2-3-1904 | | 64 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Illinois | | U.S.A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Relay | | | 4901 Cedar Ave. | | | Retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | Balto. | | Relay | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 4901 Cedar Ave. | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Oscar H. Cornwell | | | | Edith Kremer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| | | | | | | Mrs. Mabel E. Cornwell, 4901 Cedar Avenue 21227 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> <u>4100</u> | | | | | | | | <u>minutes</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio Vascular Disease</u> | | | | | | | | <u>2 1/2</u> | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>arterial hypertension</u> | | | | | | | | <u>5 yrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 16, 1968</u> , to <u>March 19, 1968</u> , that (I) (we) lost saw the deceased alive on <u>March 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Bruce Brumbaugh M.D.</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>3/20/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Bruce Brumbaugh | | | | | | 22e. ADDRESS 5609 Main St., Elkridge, Md. | | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | 3-21-1968 | | Loudon Park Crematory | | Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | MAR 22 1968 | | <u>Charles Jones</u> | | |

03980

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

| | | | | | | | |
|--|---------|---|------------------|---|-------------------------------------|---|--------------------------------|
| 03656 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03637 | |
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M |
| ANNA | | | | CROKER | March 18, 1968 | | 7:45 PM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Female | White | | Nov. 30, 1889 | | 78 YRS. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Penna. | | U.S.A. | | | | Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Dundalk | | 83 Kinship Road | | At home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | Baltimore | | Dundalk | | 83 Kinship Road. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| Matthew | | Reinert | | Anna | | 213-07-2765 D | |
| 17. INFORMANT | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertension + A-S-C-V-Narose</u>
412.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>443.8</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>15 mks</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1950</u> , 19 <u>68</u> , to <u>3/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/8/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE
<u>M.B. Davis</u> | | 22c. DATE SIGNED
<u>3/19/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. ADDRESS | | | |
| M.B. Davis, M.D. | | 6800 Morningside Road. 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3/20/68 | | Baltimore National Cemetery | | Baltimore, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Ulrich Funeral Home, Dundalk, Md. | | DATE | | MAR 21 1968 | | | |

03634

RECEIVED

03630

RECEIVED
FEB 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 03657 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 03638 | | | | | |
| 1. DECEASED-NAME (Type or print) <u>Grace</u> <u>E.</u> <u>Cullison</u> | | | | 2a. DATE OF DEATH <u>March</u> Month <u>10</u> Day <u>68</u> Year | | 2b. HOUR <u>M</u> | | | |
| 3. SEX <u>Female</u> | | 4. RACE <u>White</u> | | 5. DATE OF BIRTH <u>Dec. 27, 1902</u> | | 6. AGE (In years last birthday) <u>65</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <u>Balto. City</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>Baltimore</u> Md. | | | |
| 10. CITY OR TOWN OF DEATH <u>Reisterstown</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Mantau Mill Rd.</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Md.</u> | | 13b. COUNTY <u>Balto.</u> | | 13c. CITY OR TOWN <u>Reisterstown</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <u>Mantau Mill Rd.</u> | |
| 14. FATHER'S NAME First <u>Guy</u> Middle <u>W.</u> Last <u>Yingling</u> | | | | 15. MOTHER'S MAIDEN NAME First <u>Cona</u> Middle <u>E.</u> Last <u>Brown</u> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <u>215-32-1527 B.</u> | | 17. INFORMANT Address <u>Mr. Albert F. Cullison Reisterstown, Md.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
<u>2509</u> DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio Vascular Disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>30 min.</u>
<u>20 yrs.</u>
<u>20 yrs.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>260X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-7-37</u> , 19 <u>37</u> , to <u>3-10-68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan. 18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>D.D. Caples M.D.</u> | | | | 22c. DATE SIGNED <u>3-11-68</u> | | 22d. PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u> | | | |
| 22e. ADDRESS <u>6 Hanover Rd., Reisterstown, Md. 21136</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>March 13, 68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Dover Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Butler</u> <u>Balto.</u> <u>Md.</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>J. F. Eline & Sons Reisterstown, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>MAR 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |

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03623

22. 22. 22.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|---|--|--|--|---|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Josephine D'Alborte</i> | | | | | | 2a. DATE OF DEATH Month <i>March</i> Day <i>8</i> Year <i>1968</i> | | | 2b. HOUR <i>5:50 PM</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>10-21-83</i> | | | 6. AGE (In years lost birthday) <i>84</i> YRS. | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN <i></i> |
| 7a. BIRTHPLACE (State or foreign country) <i>Italy</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>Italy</i> ✓ | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Catonville, MD.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Summit Nursing Home</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Cleaning Lady</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>unknown</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | | 13b. COUNTY <i>Baltimore</i> | | | 13c. CITY OR TOWN <i>BALTO. MD.</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>3703 E. Pratt St.</i> | |
| 14. FATHER'S NAME First <i>Vito</i> Middle <i>Puliafico</i> Last <i></i> | | | | | | 15. MOTHER'S MAIDEN NAME First <i>Angela</i> Middle <i>Oliver</i> Last <i></i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i></i> (If yes give war or dates of service) <i></i> | | | | 16b. SOCIAL SECURITY NO. <i>220-18-4496</i> | | 17. INFORMANT Address <i>Angela Oliver, dght, 3301 Ramona Ave. 13</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia left lower lobe</i>
<i>4369</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Arteriosclerotic vascular disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cerebral vascular accident</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>331x</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION <i></i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i> | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i> P.M. <i></i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i> | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i> | | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June 15, 1967</i> , to <i>March 8, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>S. Kera</i> | | | | | | DEGREE <i></i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <i>3/8/68</i> | | |
| 22d. PHYSICIAN'S NAME (Type) <i>E. KASAITIS, M.D.</i> | | | | | | 22e. ADDRESS <i>1801 FREDERICK RD BALTO 28</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>3/12/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Schimunek Funeral Home, Inc.</i> ADDRESS <i>3331 Brehms Lane</i> | | | | | | 25a. REC'D BY REGISTRAR DATE <i>MAR 12 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| 03659 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03640 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|---------------------------|--|--|------------------|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
ISADORE A. DANENBERG | | | | | | | | | | Month Day Year
March 25, 1968 | | | | | | | | | | A M
1:55 | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Male | | | White | | | February 5, 1918 | | | 50 YRS. | | | MONTHS DAYS | | | HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| BALTIMORE Maryland | | | U.S.A. | | | | | | Baltimore Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Towson | | | St. Joseph Hospital | | | Dept. of Education | | | ADMINIS. | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Maryland | | | BALTO | | | Baltimore | | | | | | 2903 Chokeberry Ct. 21209 | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BENJAMIN DANENBERG | | | ANNA ? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | |
| YES | | | W.W. TT | | | MRS. DONA DANNENBERG, 2903 CHOKESBERRY COURT | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Massive pulmonary infarction of left lung | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4270 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Congestive heart failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4341 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 20, 1968 , to March 25, 1968 , that (X) (we) last saw the deceased alive on March 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Ines Cilliani</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | 22c. DATE SIGNED March 25, 1968 | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Ines Cilliani, M.D. | | | | | | | | | | | | | | | | | 22e. ADDRESS 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | 3-26-68 | | | BALTIMORE HEBREW | | | REISTERSTOWN, MARYLAND | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN ROAD | | | | | | | | | | | | | | | | | DATE MAR 26 1968 | | | <i>Charles Young</i> | | | | | | | | | |

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WIMATYER

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 13 Film G399
4/2/68 k Items 2415-2418
Eleanor 03600
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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| | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Eleanor</i> | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>18</i> Year <i>1968</i> | | | 2b. HOUR
<i>11 P.M.</i> | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>June 5, 1887</i> | | | | 6. AGE (In years last birthday)
<i>80</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Cockeysville</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Md. Masonic Home</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> COUNTY <i>Baltimore</i> | | | | 13c. CITY OR TOWN
<i>Baltimore</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1 Elmont Ave.</i> | | | | |
| 14. FATHER'S NAME First <i>Joseph</i> Middle <i>-</i> Last <i>Emge</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Anna</i> Middle <i>-</i> Last <i>Baker</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>212-01-2538B</i> | | 17. INFORMANT
Address <i>Masonic Home Records Balto Md.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebrovascular Hemorrhage Multiple</i>
<i>4369</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>331X</i>
(b) <i>fracture hip. Rt</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Multiple Deleterious Illness</i> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<i>Cerebro Vascular accident</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
<i>2 12 1968</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<i>Fell off chair</i> | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)
<i>Masonic home</i> | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<i>Cockeysville Balto Md</i> | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>August 18, 1965</i> , to <i>March 18, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 18, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <i>4-PM. 3/18/68 Natural causes</i> | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>James H. Hamed MD</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/18/68</i> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>JAMES H. HAMED MD</i> | | 22e. ADDRESS
<i>MASONIC HOME, Cockeysville, Md</i> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/18/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Baltimore Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State)
<i>Baltimore, Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Wm. Cook-Brooks Towson 1050 York Rd. 21204</i> | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 22 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral files. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|-----------------------|---|--|---|--|---|----------------------|---|--|---|--|--------------------|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
JAMES | | | Middle
J. | | | Last
DAVEY | | | 2a. DATE KNOWN OF DEATH
Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> | | 2b. HOUR
11:10P | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/22/97 | | 6. AGE (In years last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS
HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD
Month 3 Day 3 Year 1968 | | 2d. HOUR
11:10P | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
CALIFORNIA | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
SPECIAL POLICE | | | | 12b. KIND OF BUSINESS OR INDUSTRY
U.S. GOVERNMENT | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | | | 13c. CITY OR TOWN
EDGEWATER | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
ROUTE 3, Box 154 | | | |
| 14. FATHER'S NAME
First THOMAS Middle DAVEY Last DAVEY | | | | 15. MOTHER'S MAIDEN NAME
First ALICE Middle HENNESSEY Last HENNESSEY | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | | | 16b. SOCIAL SECURITY NO.
WW 1 214-54-8564 | | | | 17. INFORMANT ADDRESS
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT
887X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) TERMINAL PNEUMONIA
DUE TO, OR AS A CONSEQUENCE OF
(c) FRACTURE RIGHT HUMERUS | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 HOURS
2 DAYS
9 DAYS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
9040 | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/2/68 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
T PNEUMONIA | | | | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 2/22/68 P.M. 9 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
FELL AT HOME | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
HOME | | | | 21f. LOCATION Street or R.F.D. No. Route 3, Box 154, Edgewater, Maryland City or Town Edgewater County Maryland State Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
MELVIN B. DAVIS | | | | CHIEF MEDICAL EXAMINER
M.D. MELVIN B. DAVIS, M.D. | | | | ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
3/4/68 | | | | | | | |
| EXAMINER'S NAME (Type)
MELVIN B. DAVIS, M.D. | | | | ADDRESS
6800 MORNINGTON RD. BALTO., MD. 21222 | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
3/6/68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | |
| 24. FUNERAL DIRECTOR
Beverley E. Hopping | | | | ADDRESS
HOPPING FUNERAL HOME | | | | 25a. REC'D BY REGISTRAR
DATE MAR 6 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |
| | | | | ANNAPOLIS, MARYLAND | | | | | | | | | | | | | | | |

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RECEIVED BY THE SECRETARY OF THE ARMY
1950 JAN 10 10 10 AM

FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03662

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03643

| | | | | | | | | | | |
|--|-----------------|---|---|---|---------------------------------|---|--|--|---|---------------|
| 1. DECEASED-NAME
(Type or Print) | | | First
SCOTT | Middle
ANDREW | Last
DAVIS | 2a. DATE KNOWN
OF DEATH | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year | 2b. HOUR
M |
| 3. SEX
Male | 4. RACE
Cau. | 5. DATE OF BIRTH
Sept. 15, 1960 | 6. AGE (in years
last birthday)
7 YRS. | IF UNDER 1 YEAR
MONTHS OAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | 2d. HOUR
M | |
| 7a. BIRTHPLACE (State or foreign
country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
D.O.A. St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Student | | | 12b. KIND OF BUSINESS OR
INDUSTRY
School | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
611 Round Oak Road | | |
| 14. FATHER'S NAME
First Middle Last
Russell H. Davis | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Jane T. Phillips | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
Russell Davis, | | | ADDRESS
Same as # 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Strangulation</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>929 X</u>
(b) <u>Hanging</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Sudden</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>936.0</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
6:30 P.M. 3/26/68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>Fell off shed with nose around neck</u> | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
<u>Yard of Home</u> | | 21f. LOCATION-Street or R.F.D. No.
<u>Apparatus Plant Acting Henry State</u> | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE
<u>Charles F O'Donnell</u> | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
<u>3/26/68</u> | |
| EXAMINER'S NAME (Type)
<u>Charles F O'Donnell</u> | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE
<u>March 28, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Dulaney Valley Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Cockeysville, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Wm. Cook-Brooks Towson,</u> | | | 1050 York Road
Towson, Maryland 21204 | | | 25a. REC'D BY REGISTRAR
DATE
<u>MAR 29 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

88888

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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BUREAU OF PLANT INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 03663 | | | | | | | | | | 03644 | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|---|---|--|--|--|--------------------------------|---|--|--|--|--|
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) WILLIAM HOWARD DAY, JR | | | | | 2a. DATE OF DEATH
Month MARCH Day 3 Year 1968 | | | | | 2b. HOUR
6:13AM | | | | | | | | | |
| 3. SEX
MALE | | | 4. RACE
NEGRO | | | 5. DATE OF BIRTH
10/1/20 | | | 6. AGE (In years
last birthday)
47 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) BALTIMORE | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
VETERANS ADMIN. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
LABORER | | | 12b. KIND OF BUSINESS OR
INDUSTRY
CONSTRUCTION | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2755 RIGGS AVENUE | | | | | | | |
| 14. FATHER'S NAME First Middle Last
WILLIAM HOWARD DAY, SR. | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LOTTIE | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO.
217 14 77 15 | | | 17. INFORMANT Address
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
404X
IMMEDIATE CAUSE (a) PULMONARY CONGESTION & EDEMA
DUE TO, OR AS A CONSEQUENCE OF
(b) MYOCARDIAL HYPERTROPHY
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTERIOLAR NEPHROSCLEROSIS | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
DAYS
1 YEAR
YEARS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from JAN 13 , 19 68 , to MAR 3 , 19 68 , that 1 (we) lost
saw the deceased alive on MAR 3 , 19 68 , and that in my (our) opinion death occurred on the date and hour and from the
causes stated above, 1 (we) (did) not view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Neilon Neilson, M.D. DEGREE ATTENDING <input type="checkbox"/> MED. <input type="checkbox"/> STAFF <input checked="" type="checkbox"/>
PHYS. DIRECTOR PHYS. PHYS. | | | | | | | | | | 22c. DATE SIGNED
3/3/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) NEILON NEILSON, M.D. | | | | | | | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | | |
| 23a. BURIAL, CREMATION,
SPECIAL (Specify) BURIAL | | | 23b. DATE
3-7-68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Elroy O. Wilson | | | | | | | | | | 25a. REC'D BY REGISTRAR
Elroy O. Wilson | | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | | |
| #2300 Orleans Street Baltimore, Md. | | | | | | | | | | | | | | | | | | | |

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0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03664 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03645 | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|-----------------------------------|--|--|----------|----------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| CLAIRE M. DEMING | | | | | | | | | | 3/16/68
Month Day Year | | | 8:20 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Female | | White | | Feb. 11, 1882 | | | | 86 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| Balto., Md. | | USA | | | | Baltimore Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Towson, Md. | | Dulaney-Towson Nursing Home | | | | Homemaker | | | | ----- | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| Md. | | Baltimore | | Balto. | | | | 406 Colleen Rd. | | | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First Middle Last | |
| Edwin Murray | | | | | | | | | | Frances Wallace | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | Address | | | |
| no | | | | - | | Records-Nuraing Home | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis - | | | | | | | | | | | | | | | |
| 437.9 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (b) General Arteriosclerosis - | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) Sexuality. | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 334X | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-7-66, to 3/16/68, that (I) (we) last saw the deceased alive on 3/15/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | 22c. DATE SIGNED | | | |
| Anthony Carozza | | | | | | | | | | | | 3-18-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e. ADDRESS | | | |
| Abbhony Carozza, M.D. | | | | | | | | | | | | 5217 York Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) | | (County) | | (State) | | | |
| Burial | | 3/19/68 | | Cathedral Cem. | | | | Balto. | | Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Mitchell-Wiedefeld Home-6500 York Rd. 21212 | | | | | | | | | | | | DATE MAR 26 1968 | | James J. Jones | |

03843

03866

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Handwritten notes and stamps, including dates like "Feb. 11, 1968" and "Feb. 12, 1968", and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) HARRY | | | First Middle DIEHL | | | Last | | | 2a. DATE OF DEATH
Month MAR Day 19 Year 68 | | | 2b. HOUR
M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
AUG. 12, 1895 | | | 8. AGE (In years
lost birthday) 72 YRS. | | IF UNDER 1 YEAR
MONTHS 7 DAYS 2 | | IF UNDER 24 HRS.
HOURS 7 MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTO. | | | | | | Md. | |
| 10. CITY OR TOWN OF DEATH
ESSEX | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) 242 N. MARLYN | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY OIL | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD | | | 13b. COUNTY BALTO | | 13c. CITY OR TOWN ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
242 N. MARLYN | | | | |
| 14. FATHER'S NAME
First HENRY Middle DIEHL Last | | | 15. MOTHER'S MAIDEN NAME
First ELIZABETH Middle MEISTER Last | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) YES (If yes give war or dates of service) WW I | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
CHARLES DIEHL | | | Address
242 N. MARLYN | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
4409
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) Generalized Atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4500 | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 56 , to March , 19 68 , that (I) (we) last
saw the deceased alive on March 18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Robert J. Lyden | | | DEGREE M.D. | | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S
NAME (Type) ROBERT J. LYDEN | | | 22e. ADDRESS
6402 GOLDEN RING RD. | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | 23b. DATE
3/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD | | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | | | | | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | ADDRESS
300 N. ... | | | 25a. REC'D BY REGISTRAR
DATE MAR 21 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles ... | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | First
LOUISE | | Middle | | Last
Dieterich
DIETRICH | | 2a. DATE OF DEATH
March Month 6 Day 1968 ear | | 2b. HOUR
9 A M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
8/17/82 | | 6. AGE (In years
lost birthday)
85 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Wash., D. C. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
154 Sanford Ave. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Catons. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
154 Sanford Ave. 21228 | | | |
| 14. FATHER'S NAME
First
Carl | | Middle
Dieterich | | Last
Dieterich | | 15. MOTHER'S MAIDEN NAME
First
Caroline | | Middle
- | | Last
- | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
219-54-4849 | | 17. INFORMANT
Address
Mrs. Thelma Troublefield, 154 Sanford Ave. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4403 X IMMEDIATE CAUSE (a) Unemia
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial infarction & Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) 12 yrs
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
446 X Generalized arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3.5.68 to 3.6.68 , that (I) (we) last
saw the deceased alive on 3.5.68 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Justin Kudirka | | DEGREE | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3.6.68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Dr. Justin Kudirka | | 22e. ADDRESS
2151 Wilkens Ave., Balto., Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE MAR 11 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | |
|---|---------|---|---|---|---|--|---|--|--------------------------------------|---|------|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Lost | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR | |
| BENJAMIN | | F | DILLMAN JR | | 3-23 | | 19 | 68 | 11 | AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS | DAYS | IF UNDER 24 HRS
HOURS | MIN. | 2c. DATE PRONOUNCED DEAD
Month | | |
| MALE | W | SEPT 21-1918 | | 49 YRS. | | | | | 3 | Day 23 | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| PA. | | U.S.A. | | | | BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| ESSEX | | | 302 ENDSLEIGH RD | | | MACHINIST | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD. | | | BALTO | | ESSEX | | | | 302 ENDSLEIGH RD | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| BENJAMIN | | | F | DILLMAN | ESTHER | REED | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | ADDRESS | | | |
| YES | | | WWII | | 174-16-9515 | | | IDA DILLMAN | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>A-S-C-V-Used</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL
SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S
NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 3-26-68 | | | |
| MELVIN B. DAVIS | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) 6800 MORNINGTON RD. 21222 | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | 3/26/68 | | BELAIR MEM. | | BELAIR HARFORD MD | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| J. G. CONNELLY SONS | | | | 300 HAGE AVE | | | | DATE 27 1968 | | Charles Judge | |

03550

03550

RECEIVED

Handwritten notes and stamps, including a large circular stamp in the lower center.

03550

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| 03668 | | | | | | | | | | 03649 | | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|---------------------------------|--|-----------------|--|---|--|--------------------------|--|--|---|--|-----------|--|--|------------------------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | | | First Middle Last | | | | | 2a. DATE KNOWN OF DEATH | | | | | 2b. HOUR | | | | | | | | | |
| GEORGE | | | | | JOHN | | | | | DIMATTEI | | | | | <input checked="" type="checkbox"/> Month Day Year
3-27 1968 | | | | | 4:10 P.M. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | | | | | 2d. HOUR | | | | | | | |
| Male | | White | | 20 Jan. 1942 | | 26 YRS. | | MONTHS DAYS | | HOURS MIN. | | March Day 27, Year 19 68 | | | | | 4:10 P.M. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| Maryland | | | | | U.S. | | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | BALTIMORE | | | | | Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Randallstown | | | | | Balt. Co. General Hospital | | | | | Iron Worker | | | | | Construction | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? | | | | | 13e. STREET AND NUMBER | | | | |
| Md | | | | | Anne Arundel | | | | | Pasadena | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | Rte. 9 Box 237 | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | |
| Charles | | | | | George | | | | | Dorothy M. | | | | | Charles G. DiMattei-Same as # 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | | | | | | | | | |
| PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple traumatic injuries
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | 902.3 | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | | | 21b. TIME OF INJURY Month, Day, Year | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | |
| CAUSE OF DEATH | | | | | 3:45 P.M. 3-27 1968 | | | | | Slipped and fell from scaffold | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. | | | | | City or Town | | | | | County | | | | |
| Construction of school | | | | | Wymans Rd. | | | | | Randallstown | | | | | Baltimore Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | Charles S. Springate, M.D. | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | 22b. DATE SIGNED | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | Charles S. Springate, M.D. | | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | March 28, 1968 | | | | | | | | | |
| DEPUTY MEDICAL EXAMINER | | | | | ADDRESS (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) | | | | | (County) (State) | | | | |
| Burial | | | | | 4/1/68 | | | | | Glen Haven Memorial Pk. | | | | | Glen Burnie, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | R.V. Singleton/ Glen Burnie, Maryland | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | | | | | DATE | | | | | APR 1, 1968 | | | | | | | | | |

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WEEKLY REPORT OF DEATH

03843

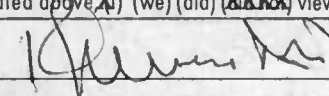
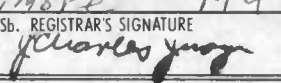
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APR 1 1958

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
JAMES | | | Middle
EDWARD | | | Last
DINGLE, Sr. | | |
| 3. SEX
MALE | | | 4. RACE
NEGROID | | | 5. DATE OF BIRTH
MAY 25, 1911 | | | 2a. DATE OF DEATH
Month MARCH Day 16 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
S.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
KITCHEN HELPER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First
EDWARD | | | Middle
DINGLE | | | Last
HATTIE | | | 15. MOTHER'S MAIDEN NAME First
MC FADDEN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | | 16b. SOCIAL SECURITY NO.
213 09 86 89 | | | 17. INFORMANT
CLINICAL RECORDS VA HOSP FT HOWARD, MARYLAND | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA, RECENT
150 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 150 X
(b) WIDE SPREAD METASTATIC CARCINOMA
DUE TO, OR AS A CONSEQUENCE OF
(c) SQUAMOUS CELL CARCINOMA ESOPHAGUS
(SURGICALLY REMOVED), OLD
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PULMONARY EMPHYSEMA, OLD; ESOPHAGOGASTRECTOMY, OLD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAR 6 , 19 68 , to MAR 16 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAR 16 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
 | | | DEGREE
MD | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
MAR 17, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
RODOLFO G. MIRO, M.D. | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3/21/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NAT. | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
MORTON & DYETT FUNERAL HOME
1701 LAURENS, BALTIMORE, MD | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE MAR 19 1968 | | | 25b. REGISTRAR'S SIGNATURE
 | | |

03650

03650

NAME: JAMES HOWARD ALLEN DOB: 18 MARCH 1928 2:42

WIFE: MARGARET HOWARD DOB: 25 MAY 1914 1:10

U.S.A. BIRTHPLACE: BIRMINGHAM

PORT FORWARD: VETERANS ADMIN HOSPITAL

RECEIVED: 1000 BRISTOL STREET

RECEIVED: 1000 BRISTOL STREET

113 02 22 02 113 02 22 02 113 02 22 02

BIRMINGHAM, ENGLAND

WIFE: MARGARET HOWARD (SURVIVOR)

RECEIVED: 1000 BRISTOL STREET

BIRMINGHAM, ENGLAND

YES

X

NAME: JAMES HOWARD ALLEN DOB: 18 MARCH 1928 2:42

18 MARCH 1928 2:42

RECEIVED: 1000 BRISTOL STREET

BIRMINGHAM

RECEIVED: 1000 BRISTOL STREET

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 03670 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03651 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--------------------------------|---|--------------------------------|
| 1. DECEASED-NAME (Type or print) CHARLES C. DISHMAN | | | | | | 2a. DATE OF DEATH Month 3 Day 1 Year 1968 | | | 2b. HOUR 5:30 PM | | |
| 3. SEX M | | 4. RACE WHITE | | 5. DATE OF BIRTH 6/24/17 | | | 6. AGE (In years lost birthday) 50 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH CATONSVILLE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) SPRING-GROVE | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Trucking Business | | 12b. KIND OF BUSINESS OR INDUSTRY TRUCK | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | | 13b. COUNTY Howard | | 13c. CITY OR TOWN Elkridge | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6501 OLD WASHINGTON RD. | |
| 14. FATHER'S NAME First Charles E. Middle Dishman Last DOWN | | | | | | 15. MOTHER'S MAIDEN NAME First UNKNOWN Middle Sarah Last Miller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Unknown) Yes, no, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 218-10-8899 | | 17. INFORMANT JANE DISHMAN Address 6501 OLD WASH. RD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4369 IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
(b) <u>Cerebral Vascular Accident</u>
(c) <u>14 mos</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X NONE | | | | | | | | | | | |
| 19a. DATE OF OPERATION NONE | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/28 , 19 67 , to 3/1 , 19 68 , that (I) (we) last saw the deceased alive on 3/1 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Fritz Kobler M.D. | | | | | | | | 22c. DATE SIGNED 3/1/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) FRITZ KOBLER | | | | | | | | 22e. ADDRESS 15. Ambros Avenue Catonsville. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 3-5-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery | | 23d. LOCATION (City or Town) (County) (State) Howard County, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. | | | | | | 25a. REC'D BY REGISTRAR 21229 | | 25b. REGISTRAR'S SIGNATURE John C. Young | | | |
| | | | | | | DATE MAR 5 1968 | | | | | |

03820

03820

03820

THE NATIONAL BUREAU OF INVESTIGATION
WASHINGTON, D. C.

REPORT OF THE
SPECIAL AGENT IN CHARGE

TO THE DIRECTOR

FROM THE

FIELD OFFICE

AT

DATE

BY

FILE

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the form. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03671

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03652

| | | | | | | | | | | |
|---|---------|--|--------|---|-------------------------|---|--------------------------------|---|-------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN OF DEATH | | <input type="checkbox"/> Month | <input type="checkbox"/> Day | <input type="checkbox"/> Year | 2b. HOUR |
| Gustav | | | | Dittmar | DATE MATED | | <input type="checkbox"/> 3 | <input type="checkbox"/> 15 | <input type="checkbox"/> 1968 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Male | White | 4-30-1885 | | 82 YRS. | MONTHS | | DAYS | | Month | Day |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 9. COUNTY OF DEATH | | | | 2d. HOUR | |
| Baltimore | | U.S.A. | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | Baltimore | | | | M | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Towson | | St. Joseph's | | Selfemployed | | Grocer | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Md | | Baltimore | | Perry Hall | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21236 | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Henry | | Anna | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | 218-32-1212 | | Miss M. Evelyn Dittmar 4102 Pine Dale Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Hemorrhage | | | | | | | | | | Sudden |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Hypertension | | | | | | | | | | 10 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) Cardio Renal Vascular Disease | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | |
| 442 X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| CAUSE OF DEATH | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED |
| | | | | | | | | | | 3/15/68 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 3-18-1968 | | Parkwood Cemetery | | Baltimore, Co. Md. | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lassahn Funeral Home | | 7401 Belair Road | | MAR 22 1968 | | Charles Jones | | | | |

05350

UNITED STATES DEPARTMENT OF JUSTICE

05351

UNITED STATES DEPARTMENT OF JUSTICE



[Faint, illegible handwritten text]

DO NOT WRITE IN THESE SPACES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4
30M REV. 1968

| 03672 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03653 | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|---------------------------------|---|--|--|------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| George | | | | | | Dresch | Month | Day | Year | 11 A.M. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | Cau. | | 12-31-1899 | | | 68 YRS. | | MONTHS | DAYS | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Balto. | | U.S.A. | | | | Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Balto. | | | 6802 Beech Ave. | | | Electrician | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md | | | Balto. | | | | | | | 6802 Beech Avenue 36 | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| John | | | | | Dreisch | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 218-01--50 | | | Noreen Bowers | | | Southbend Ind. 1438 E. Bowman St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 3032 | | | | | | | | | | 2 hrs | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Depression of myocardium, lived 10 yrs | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Chronic alcoholism 15 yrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | |
| 322.1 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 1968, to March 1968, that (I) (we) last saw the deceased alive on Feb 20 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death with permission of med. examiner | | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | | | | |
| Richard R. Digler | | | | | | RICHARD R. DIGLER 1. W. Overlea AVE - Balto 6 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 3-14-68 | | Parkwood Cem. | | | balto. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lasscha Funeral Home 1401 Belair Road #6 | | | | | | DATE MAR 18 1968 | | Charles Young | | | | |

03083

03083

03083



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-141
30M REV. 1/68

03673

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03654

| | | | | | | | | | |
|---|--|---|---|---|---|---|-------------------|---|-----|
| 1. DECEASED-NAME
(Type or print) BEATRICE BERYL DZIEKLINSKI | | | First Middle Last (Glass) | | 2a. DATE OF DEATH
3 Month 30 Day Year 68 | | 2b. HOUR
3 P M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
12-16-16 | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | Md. |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GREATER BALTO. MED. CENTER | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
— | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
Edgemere | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2417 CAROLYNE AVE | |
| 14. FATHER'S NAME
First Middle Last
HERBERT HANCOCK | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
EFFIE LAM | | | Address
#13- | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
220-12-7742 | | 17. INFORMANT
Husband, Mr. Alexander J. Dzieklinski a,b,c, | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General Metastatic Ca. of the Breast
174X
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
170X | | | | | | | | | |
| 19a. DATE OF OPERATION
2/6/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma Ri Breast | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/29 , 19 68 , to 3/30 , 19 68 , that (1) (we) last saw the deceased alive on 3/30 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
E.R. Soudijn M.D. | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/30/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
E.R. Soudijn | | 22e. ADDRESS
8415 6701 North Charles St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
April 3-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Belair Memorial | | 23d. LOCATION (City or Town) (County) (State)
Belair, Maryland | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, Dundalk, Maryland 21222 | | ADDRESS | | 25a. REC'D BY REGISTRAR
APR 2-1968 | | REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

03879

03879

03879

(Class)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Lucille | | | First Middle Last Edelmann | | | 2a. DATE OF DEATH
Month March Day 31 Year 68 | | 2b. HOUR 6.00 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
7-26-88 | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS 79 DAYS 79 HOURS 79 MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
159 N. Decker Ave. | |
| 14. FATHER'S NAME
First Middle Last
HENRY F. SCHLESINGER | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
EMMA FISCHER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
NO | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
HOWARD EDELMANN | | Address
6625 HUDSON | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute peritonitis
5400
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) perforated acute appendicitis
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
5501 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/27/ , 19 68 , to 3/31/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/31/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
William | | | | | | DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
April 1, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | | 22e. ADDRESS
7620 York Rd., Towson Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
4/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | | | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | | ADDRESS
300 MALE | | 25a. REC'D BY REGISTRAR
APR 3 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 475 (4)
30M REV. 7-68

| 03675 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03656 | | | | | | | | | |
|---|--|--|---------|--|--|------------------|--|--|---------------------------------|--|--|-----------------|--|--|--|--|--|-------|--|------------------------|------|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | | | | | | | | | | |
| Florence Eluira Egerton | | | | | | | | | | March 30 68 | | | | | | | | | | 4:10 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | |
| Female | | | White | | | 2-12-1880 | | | 88 YRS. | | | MONTHS | | | DAYS | | | HOURS | | | MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Baltimore Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Towson | | | | | St. Joseph Hospital | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | Baltimore | | | | | Parkville | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 2615 Wendover Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| George Shea | | | | | Elizabeth Kirby | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| NO | | | | | 217 09 9370 | | | | | Mrs Ethel K. Trust 2615 Wendover Rd. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Right encephalomalacia</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>437.9</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) <u>Arteriosclerotic cerebral vascular disease</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>Right pulmonary emboli; Right broncho-pneumonia.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>3/14/</u> , 19 <u>68</u> , to <u>3/30/</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>3/30/</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Samuel B. M.D.</u> | | | | | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22c. DATE SIGNED <u>March 31, 1968</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Dr. S. Lee, M.D.</u> | | | | | | | | | | 22e. ADDRESS <u>7620 York Road, Towson, Md.</u> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| | | | | | <u>4/2/68</u> | | | | | <u>Mount Carmel Cemetery</u> | | | | | <u>Baltimore Maryland</u> | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>HENRY SANDER & SONS INC BALTO. MD.</u> | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE <u>APR 2 1968</u> | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

03834

03833



TO THE DIRECTOR, BUREAU OF REVENUE, WASHINGTON, D. C.

FROM THE CHIEF, BUREAU OF REVENUE, WASHINGTON, D. C.

RECEIVED

1918

1918

1918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------------------------|-------|--|---|--|--------------|---|------------------------------|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 03676 | | | | | 03657 | | | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | | |
| a. COUNTY | | Baltimore | | | a. STATE | | Maryland | | | | |
| | | MARYLAND | | | b. COUNTY | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | Catonsville | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | | | | | | |
| | | | | | Baltimore | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | | d. STREET ADDRESS | | | e. IS RESIDENCE ON A FARM? | | | |
| Shady Nook Nursing Home 1002 N. Rolling Rd. | | | | | 607 Maude Ave. 21225 | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) | | | First | | Middle | | Last | | 4. DATE OF DEATH | | |
| John | | | James | | Elliott | | March 17, 68 | | 19 68 | | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH | | 9. AGE (in years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | Jan. 4, 1878 | | 90 yrs. | | Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | |
| Shipwright | | | | U. S. Coast Guard | | Port Royal Virginia | | | U. S. A. | | |
| 13. FATHER'S NAME | | | | | 14. MOTHER'S MAIDEN NAME | | | | | | |
| John H. Elliott | | | | | Elizabeth Sylvia | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | None | | Mrs. Jean Mitchell | | 607 Maude Ave. 21225 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebrovascular thrombosis
4129 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic cardiovascular disease
1 yr +
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
4 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
4221 | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY | | Month, Day, Year | | 20d. INJURY OCCURRED | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) (State) | |
| Hour a.m. p.m. | | 19 | | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 17, 1968, to March 6, 1968, that (I) (we) last saw the deceased alive on March 6, 1968, and that death occurred at 5:55 PM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | M.D. ATTENDING PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| John A Nesbitt Jr. | | | | | | 4 | | | | 3-7-68 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | | 22d. ADDRESS | | | | | |
| JOHN A NESBITT JR | | | | | | 1009 Fretwell Rd - Baltimore Md 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) | | (State) | | | |
| Burial | | 3/19/68 | | Cedar Hill Cemetery | | Ritchie Highway | | Anne Arundel | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| McCall F. H. | | | | | | 237 Patapsco Ave. 21225 | | MAR 11 1968 | | Charles J. [Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03677 | | | | | | | | | | 03658 | | | | | | | | | |
|--|--|--|------------------------------|--|--|--|--|--|--------------------|---|--|---------------------------------|-----------------|------------------------|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | |
| Israel | | | | | Clyde | | | | | Engel | | | | | Mar. Month 29 Day 68 Year 4:25 PM | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | |
| MALE | | | WHITE | | | 10-11-1893 | | | | 74 YRS. | | | MONTHS DAYS | | HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | |
| RUSSIA | | | U.S.A. | | | | | | BALTIMORE Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Garrison | | | | | NURSING HOME | | | | | ACCOUNTANT | | | | | SELF EMPLOYED | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | |
| STATE | | | | | BALTIMORE | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 6001 PARK HIGHTS. AVE., APT. 40 | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | |
| First Middle Last | | | | | First Middle Last | | | | | | | | | | | | | | |
| ABRAHAM ENGEL | | | | | SARAH FAYE ? | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | |
| YES | | | | | W. W. T | | | | | MRS. BESSIE ENGEL, 6001 PARK HIGHTS. AVE., APT. 40 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pulmonary Edema | | | | | | | | | | | | | | | 8 hrs. | | | | |
| 436.0 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 331X | | | | | | | | | | | | | | | | | | | |
| (b) Cerebro-Vascular Accident | | | | | | | | | | | | | | | Nov. 30. 67 | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) Hypertensive Vascular Disease & Atherosclerosis | | | | | | | | | | | | | | | 3 yrs | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| Broncho-pneumonia 2 day | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | City or Town County State | | | | |
| While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No. | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan, 1968, to 3-29, 1968, that (I) (we) last saw the deceased alive on 3-29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| M. W. LACOBSON MD | | | | | | | | | | 3-29-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| M. W. LACOBSON | | | | | | | | | | 6821 Reisterstown Rd Baltimore, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | | | 3-31-68 | | | | | CHIZ UK AMUNO | | | | | BALTIMORE, MARYLAND | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | | | | | | | | DATE | | | | | APR 3 - 1968 | | | | |

03834

03871

DATE 1/1/50
WHITE
U.S.A.
BALTIMORE

ACCOUNTANT
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

ASST. MGR.
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

ASST. MGR.
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

ASST. MGR.
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

ASST. MGR.
BALTIMORE
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BALTIMORE
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ASST. MGR.
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

ASST. MGR.
BALTIMORE
8001 PARK HEIGHTS AVE., BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 12-68

| 03678 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03659 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|-----------------------------|--|--|--|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| WILLIAM JOHNSON ENGLISH | | | | | | | | | | March 30, 1968 | | | | | | | | | | 10 AM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| Male | | | White | | | Sept. 23, 1892 | | | 75 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Trenton N.J. | | | USA | | | | | | Baltimore County Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Elkridge Estates, Md. | | | 34 Over Ridge Ct. | | | Electrical Engineer, Retired | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| Md. Elkridge Estates | | | Baltimore | | | Md. 21210 | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 34 Over Ridge Ct. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| William J. English | | | | | Ella W. Laverty | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| yes | | | | | W.W.I 215-07-3840 | | | | | Mrs. Myrtle L. English, Elkridge Estates | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma prostate | | | | | | | | | | | | | | | 6 years | | | | | | | | | | | | | | |
| 185X Spread to rectum | | | | | | | | | | | | | | | 5 years | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Partial obstruction rectum | | | | | | | | | | | | | | | 1 year | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 177X anemia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| No operation | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-31, 1962 to 3-30, 1968, that (I) (we) last saw the deceased alive on 3-28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE S. G. SULLIVAN M.D. | | | | | | | | | | 22c. DATE SIGNED Apr. 1 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) S. G. SULLIVAN M.D. | | | | | | | | | | 22e. ADDRESS 1129 St. Paul St. Baltimore 21202 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Cremation | | | | | Apr. 2, 1968 | | | | | Greenmount | | | | | Baltimore Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS HENRY SANDER & SONS, INC. Baltimore Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE APR 2 - 1968 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

03553

03553

WILLIAM JOHNSON WHEELER
April 17, 1892
Trenton, N.J.
All persons interested in the above case of
W. Johnson, deceased, will please send
their claims to the undersigned
at Trenton, N.J., by the 1st day of
May, 1892.

W. J. WHEELER
Trenton, N.J.
April 17, 1892
All persons interested in the above case of
W. Johnson, deceased, will please send
their claims to the undersigned
at Trenton, N.J., by the 1st day of
May, 1892.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>03673</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03660</div> | | | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|---|--|-----------------------------|
| 1. DECEASED-NAME (Type or print) GUY First ROBINSON Middle ENSOR, SR. Last | | | | | | 2a. DATE OF DEATH March Month 2 Day 1968 Year | | | 2b. HOUR M | | |
| 3. SEX Male | | 4. RACE Cau. | | 5. DATE OF BIRTH August 10, 1881 | | | 6. AGE (In years last birthday) 86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Monkton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Corbett Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY Farm | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Monkton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Corbett Road | | |
| 14. FATHER'S NAME First William Middle Henry Last Ensor | | | | 15. MOTHER'S MAIDEN NAME First Kate Middle Zora Last Robinson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Mrs. Effie Ensor, Same as # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4270 Congestive Heart failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>4341 Age</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>65</u> , to <u>3-2</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3-1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>C. Herbert Mueller MD</u> DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>3-3-68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>C. HERBERT MUELLER</u> | | | | | | 22e. ADDRESS <u>YORK Rd. PARKTON- Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 12-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY Jessop Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Sparks, Maryland | | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, ADDRESS 1050 York Road Towson, Md. 21204 | | | | | | 25a. REC'D BY REGISTRAR MAR 7 1968 DATE | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

187850

220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03680 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03661 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 20. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| First Anna Middle J Last EVERETT | | | | | | | | | | Month March Day 18, Year 1968 | | | | | | | | | | 12:10 P.M. | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | 7E UNDER 1 YEAR | | | | | 7F UNDER 24 HRS. | | | | | | | | | | | | | | |
| Female | | | | | White | | | | | July 12, 1900 | | | | | 67 YRS. | | | | | MONTHS | | | | | DAYS | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | U.S.A. | | | | | | | | | | Baltimore, | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | |
| Towson | | | | | ST. JOSEPH HOSPITAL | | | | | Homemaker | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Baltimore | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 4116 White Ave. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Karzmier Middle Jaskiewicz Last | | | | | First Frances Middle Blocheck Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | | | | 218-05-6189 | | | | | Mr James H Everett | | | | | Same | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Hepatic coma secondary to Laennec's cirrhosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/10/1968, to 3/18/1968, that (I) (we) last saw the deceased alive on 3/18/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ramon P. Lopez | | | | | | | | | | March 18, 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ramon P. Lopez, M.D. | | | | | | | | | | 7620 York Rd., Towson, Md. 21204 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | | | | | | | 3/22/68 | | | | | | | | | | Holy Redeemer | | | | | | | | | | Baltimore, Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Leonard J Rueck Inc Baltimore, Md | | | | | | | | | | DATE MAR 19 1968 | | | | | | | | | | John A. Judge | | | | | | | | | | | | | | | | | | | |

12250

DATE: _____

576-25-878 Mr. James H. Smith, JR. 10/2/87

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M. REV. 1-68

| 03681 | | | | | | | | | | 03662 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| First Middle Last
Lucy Mae Ey | | | | | | | | | | Month Day Year
3 27 1968 | | | | | | | | | |
| 3. SEX
Female | | | | | | | | | | 4. RACE
Cau | | | | | | | | | |
| 5. DATE OF BIRTH
10-11- 1899 | | | | | | | | | | 6. AGE (In years last birthday)
68 YRS. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Rosedale | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7932 33rd. St. | | | | | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Housewife | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | | | | | | | | 13b. COUNTY
Baltimore | | | | | | | | | |
| 13c. CITY OR TOWN
Rosedale | | | | | | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 13e. STREET AND NUMBER
7932 33rd. | | | | | | | | | | 13f. CITY OR TOWN
Baltimore, Md. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
Harry Henderson | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida Ward | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| 17. INFORMANT
Mrs Doris Seabrease | | | | | | | | | | Address
7932 33rd. Street | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>
<u>4129</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>longstanding myocardial ischemia and insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>10 yrs</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>10 yrs</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)
<u>4201 Coronary arteriosclerosis</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>58</u> , to <u>death</u> , 19 <u>58</u> , that (I) (we) lost saw the deceased alive on <u>few months ago</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Dr John Geldrich</u> | | | | | | | | | | 22c. DATE SIGNED
<u>3/28/1968</u> | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
John Geldrich, M. D. | | | | | | | | | | 22e. ADDRESS
8019 Philadelphia Road Balto., Md. 21237 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | | | | | | 23b. DATE
3- 30- 1968 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY
Falmwood Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Co. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Lassahn Funeral Home | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>APR 1 - 1968</u> | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | |

03000

RECEIVED OF DEPT

18900

1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1/68

03682

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03663

| | | | | | | | | | | | | | | | | | |
|--|--|-------------------------------------|---|---|---|--|---|---|---|-------------------------------|--|---|--|--------------------------------|--|-----------------------------|--|
| 1. DECEASED NAME
(Type or print) First Middle Last
ALBERT RAYMOND FARB | | | 2a. DATE OF DEATH
Month Day Year
MARCH 31 1968 | | | 2b. HOUR
10 P M | | | | | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUG 13, 1911 | | 6. AGE (In years
last birthday)
56 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST JOSEPH'S | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
SUPERVISOR | | | 12b. KING OF BUSINESS OR
INDUSTRY
CLOTHES | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MD | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3320 CLARKS LANE | | | | | | | | |
| 14. FATHER'S NAME
First Middle Last
NATHAN FARB | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
MARY FARB | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | | | | | 16b. SOCIAL SECURITY NO.
213-01-7437 | | 17. INFORMANT
MRS ROSE FARB | | Address
3320 CLARKS LANE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 day
3 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Diabetes mellitus | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/15, 1965, to 3/31, 1968, that (I) (we) lost
saw the deceased alive on 3/31 1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Manuel Levin | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
4/1/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
MANUEL LEVIN MD | | | 22e. ADDRESS
6701 PARK HEIGHTS AVE | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
APRIL 1, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
MOGEN ABRAHAM | | | 23d. LOCATION (City or Town) (County) (State)
BALTO MD | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Sydney S. Lewis & Son, INC | | | ADDRESS
Baltimore | | | 25a. REC'd BY REGISTRAR
DATE APR 2, 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

03683

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03664

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) IDA | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year MARCH 10, 1968 | | 2b. HOUR 12:00 | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1878 | | 6. AGE (In years last birthday)
89 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
POLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
GARRISON FOREST ROAD | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
GARRISON FOREST ROAD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
HERMAN NUSBAUM | | 15. MOTHER'S MAIDEN NAME First Middle Last
GOLDIE ? | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
NO | | | |
| 16b. SOCIAL SECURITY NO.
220-46-0901 | | 17. INFORMANT Address
MR. WM. TAFT FELDMAN, 507 MD. TRUST BLDG. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) BRONCHIAL PNEUMONIA
4409
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
15 yrs | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4500 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan , 1960, to March , 19 10 , that (I) (we) last saw the deceased alive on Mar 10 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Leon E Kassel MD | | 22c. DATE SIGNED
3/11/68 | | 22d. PHYSICIAN'S NAME (Type)
LEON KASSEL | | | |
| 22e. ADDRESS
3501 ST. PAUL STREET | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | | |
| 23b. DATE
3-11-68 | | 23c. NAME OF CEMETERY OR CREMATORY
CHIZUK AMUNO | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS., 6010 REISTERSTOWN | | 25a. REC'D BY REGISTRAR
MAR 12 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

03583

03583

RECEIVED
FEBRUARY 12 1954

TO: DIRECTOR, FBI
FROM: SAC, BALTIMORE

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

100-101000-1000

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

[Illegible text]

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with four copies of this certificate. Five copies of this certificate should be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 03684 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03665 | | | | | |
|--|--|---------|--------|--|---------|------------------------------------|------|--|--|---|---------------|--|---------|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First | | Middle | | Last | | | 2a. DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR OF DEATH <input checked="" type="checkbox"/> M | | | |
| ZULA | | | (KATE) | | Ferrara | | | | | | March 31 1968 | | 9:00 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR | |
| Female | | Cau. | | Oct. 13, 1898 | | 69 YRS. | | | | | | March 31 1968 | | 2:00 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Baltimore, Md. | | | | USA | | | | | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Idlewyld | | | | 600 Walker Ave. | | | | Housewife | | | | At Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | | | Baltimore | | | | Idlewyld | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 600 Walker Ave. | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First Middle Last | |
| Frank | | | | | | | | Ferrara | | Vizzini Prospera | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | | | |
| No | | | | | | | | Mrs. Frank Matassa | | | | 3614 Stoneybrook Rd. Randallstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | | | Sudden | | | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | |
| (b) Hyperbolic Cardiac | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) Renal Vascular Disease 5 yrs | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 3/31/68 | | | |
| Charles F. O'Donnell | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 4/3/1968 | | Cathedral Cemetery | | | | Baltimore, Md. | | | | | |
| 24a. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Vernon Lemmon | | | | 4611 Park Heights, Balto. Md. | | | | DATE APR 3 - 1968 | | | | Charles Judge | | | |

| NAME | ADDRESS | CITY | STATE |
|---------------------|-----------------------|------------|-------|
| J. Edgar Hoover | Washington, D.C. | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |
| Mr. J. Edgar Hoover | Department of Justice | Washington | D.C. |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03685 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03666 | | | | | |
|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) <i>Minnie C Fiedler</i> | | | | 2a. DATE OF DEATH
Month <i>March</i> Day <i>23</i> Year <i>1968</i> | | | | 2b. HOUR
<i>3 P M</i> | | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>March 15, 1889</i> | | 6. AGE (In years
lost birthday)
<i>79</i> YRS. | | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS.
HOURS <i></i> MIN. <i></i> | | | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Balto Md</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Balto.</i> | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Towson</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Chesapeake Manor</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
<i>Florist</i> | | 12b. KIND OF BUSINESS OR
INDUSTRY
<i>Florist</i> | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md</i> | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Roseburg</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>427 Buck School House Rd</i> | | | | | |
| 14. FATHER'S NAME
First <i>Henry</i> Middle <i>Diegert</i> Last <i>Katherine</i> | | 15. MOTHER'S MAIDEN NAME
First <i>Michling</i> Middle <i></i> Last <i></i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or NO <i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>215-40-0924</i> | | 17. INFORMANT
Address <i>427 Buck School House Rd. 36</i>
<i>Otto O. Fiedler</i> | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>myocardial infarction</i>
<i>410.9</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <i>myocardial infarction Feb. 18, 1968</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>Several</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>4201 Pernicious Anemia.</i> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If neither, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. <i></i> Month <i></i> Day <i></i> Year <i>19</i>
P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i> | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 5</i> , 19 <i>62</i> , to <i>Mar 23</i> , 19 <i>68</i> , that (I) (<i>we</i>) last
saw the deceased alive on <i>March 12</i> , 19 <i>68</i> , and that in (my) (<i>our</i>) opinion death occurred on the date and hour and from the
causes stated above, (I) (<i>we</i>) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Samuel Whitehouse M.D.</i> | | DEGREE <i></i> ATTENDING
PHYS. <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/25/68</i> | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) <i>Samuel Whitehouse, M.D.</i> | | 22e. ADDRESS
<i>3900 North Charles Street 21218</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>3/27/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Peter's Cath. Cem.</i> | | 23d. LOCATION (City or Town)
<i>Balto. Co</i> | | (County) <i></i> (State) <i>Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Lassalle Funeral Home</i> | | ADDRESS
<i>7401 Belair Rd
Baltimore 36 Md</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 28 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | |

43880

28882

CONFIDENTIAL

1500 North Lincoln Street, Chicago, Illinois 60612

3301

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MARY ALMEADA FIROK | | | First Middle Lost | | | 2a. DATE OF DEATH
3 Month 14 Day 68 Year | | 2b. HOUR
8:20 A. M. | | |
| 3. SEX
F | | 4. RACE
White | | 5. DATE OF BIRTH
2-24-1980 | | 6. AGE (In years lost birthday)
88 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Catonsville Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Shady Nook Nursing and Convalescent | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Fred. | | 13c. CITY OR TOWN
Thurmont | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Lost
Alonza Stull | | | 15. MOTHER'S MAIDEN NAME First Middle Lost
Savannah Pearl | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
214-54-8547 | | 17. INFORMANT Address
Franklin Firor Thurmont, Md. RFD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) arteriosclerotic cardiovascular disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs + | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19, 68 , to March 14, 19 68 , that (I) (we) last saw the deceased alive on March 9, 19 68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Joan A. Nesbitt Jr.
DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
3-14-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) JOAN A. NESBITT JR | | | | | | 22e. ADDRESS
10097 Federal Rd, Baltimore Md 21228 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Blue Ridge Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Thurmont Fred. Md. | | | | |
| 24. FUNERAL DIRECTOR
Raymond E. Greager
ADDRESS
Thurmont, Md. | | | | | | 25a. REC'D BY REGISTRAR
MAR 19 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. ... | | |

MEDICAL CERTIFICATION

03661

03661

03661



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form #M3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

0368

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03668

| | | | | | | | |
|---|-------------------------|---|------------------|---|---|---|--------------------------|
| 1. DECEASED-NAME
(Type or Print) | | First
JOHN | Middle
CRONIN | Last
FISCHER | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month Day Year March 20 1968 | | 2b. HOUR 10:30 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Feb. 16, 1957 | | 6. AGE (in years last birthday)
11 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year March 20 1968 | |
| 7a. BIRTHPLACE (State or foreign country)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1913 Searles Rd. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Student | | 12b. KIND OF BUSINESS OR INDUSTRY
School | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before)
1913 Searles Rd. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
First Middle Last
Joseph B. Fischer | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Evelyn M. Snyder | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
_____ | | 17. INFORMANT ADDRESS
Joseph B. Fischer : 1913 Searles Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Brow Tumor @
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis to Spinal, Liver etc =
DUE TO, OR AS A CONSEQUENCE OF (c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 2381 | | | | | | | |
| 19a. DATE OF OPERATION
1965 | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Brow Tumor | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
234X | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
M B Davis | | EXAMINER'S NAME (Type)
MELVIN B. DAVIS | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
MAR 22 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
March 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Sacred Heart Cemetery | | 23d. LOCATION (City or Town) (County) (State)
7401 German Hill Rd., Ba. Co., Balto., 21222, Md. | |
| 24. FUNERAL DIRECTOR
Charles S. Zeiler, | | 901 S. Conkling St.
Balto., 21224, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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1951. 10. 10. 1951

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03688
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 7b Film G399 3/27/68 kk
CERTIFICATE OF DEATH

03669

| | | | | | | | | | | | |
|--|--|---|--------|---|--|--|---------------------------|---|--|--------------------------------|--|
| 1. DECEASED-NAME
(Type or print) <i>BRONISLAWA</i> | | First | Middle | Last | 2a. DATE OF DEATH
Month <i>3</i> Day <i>16</i> Year <i>1968</i> | | 2b. HOUR
<i>1230 P</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>October-25-1881</i> | | 6. AGE (In years
last birthday) <i>86</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) <i>Poland, August</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>Poland</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Baltimore</i> | | Md. | | | |
| 10. CITY, OR TOWN OF DEATH
<i>Balto.</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<i>Shengri Le Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE <i>Md.</i> | | 13b. COUNTY
<i>Baltimore</i> | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME
First Middle Last | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
<i>212-07-5399</i> | | 17. INFORMANT
Address <i>Louis Fletcher 425 S. Drew St</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis & Congestive failure</i>
<i>410.0</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) <i>Hypertensive Cardio Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<i>2 Hrs</i>
<i>20 years</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 19 <i>48</i> , to <i>3/16</i> , 19 <i>68</i> , that (I) (we) last
saw the deceased alive on <i>3/14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Eliot W. Johnson MD</i> | | DEGREE | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>3/16/68</i> | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | 22e. ADDRESS
<i>3432 Frederick Ave
Baltimore Md 21229</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
<i>3-19-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Loudon Pk.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Thelma A. Hoffmann</i> | | ADDRESS
<i>3218 Rudan St.</i> | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 19 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. [Signature]</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|--------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
William | | Middle
B. C. | | Last
FOERSTER | | 2a. DATE OF DEATH
Month 3 Day 11 Year 68 | | 2b. HOUR
2:15 M |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
5-8-04 | | 6. AGE (In years lost birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Dependent | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Halethorpe | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
2409 Hamilton Avenue | | |
| 14. FATHER'S NAME First
Jacob | | Middle
J. | | Last
Foerster | | 15. MOTHER'S MAIDEN NAME First
Estella | | Middle
L. | | Last
Toomey |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
no | | 16b. SOCIAL SECURITY NO.
-- | | 17. INFORMANT
Address
Rosewood Records, Owings Mills, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Institutional Carcinoma Generalized
1579
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma, pancreas
DUE TO, OR AS A CONSEQUENCE OF
(c) 1578
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 1578
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 years
2 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Institutionalized 58 years Congenital Mental Deficiency | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (a) (this hospital) attended the deceased from 2/20 , 19 68 , to 3/11 , 19 68 , that (a) (we) last saw the deceased alive on 3/11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (do not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Richard A. Jones | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/11/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Richard A. Jones, M.D. | | 22e. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION (City or Town)
Baltimore, Md. | | (County) | | (State) |
| 24. FUNERAL DIRECTOR
J. F. Eline & Sons | | ADDRESS
Reisterstown, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | | |

00088

00070

RECORDS OF DEATH

NAME: William J. C. ...

DATE: 11 28 1915

PLACE: ...

CAUSE: ...

AGE: ...

SEX: ...

RELIGION: ...

EDUCATION: ...

OCCUPATION: ...

RESIDENCE: ...

DATE OF BIRTH: ...

DATE OF DEATH: ...

PLACE OF BIRTH: ...

PLACE OF DEATH: ...

DATE OF BURIAL: ...

PLACE OF BURIAL: ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 151 (4)
30M REV. 1/68

| 03690 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03671 | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | First Middle Last | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| John Francis Ford | | | | | | | | Month 3 Day 17 Year 68 | | | | 6:45 P.M. | | | |
| 3. SEX | | | | 4. RACE | | | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | | |
| Male | | | | Cau. | | | | 2/27/96 | | | | 72 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | |
| Maryland | | | | U.S.A. | | | | | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | | | Greater Baltimore Med. Center | | | | Guard | | | | Bank | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| MD. | | | | | | | | Baltimore | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | |
| John Thomas Ford | | | | Anne Walsh | | | | Yes | | | | 217 05 5548 | | | |
| 17. INFORMANT | | | | Address | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pericarditis</u> | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | 1519 | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of stomach with wide</u> | | | | | | | |
| | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF (c) <u>spread metastases</u> | | | | | | | |
| | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| | | | | | | | | 151X | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> , 19 <u>68</u> to <u>3/17</u> , 19 <u>68</u> , that (I) (we) lost <u>3/16</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | 22c. DATE SIGNED | | | | 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | |
| | | | | 3/17/68 | | | | R. Breitenecker, M.D. | | | | 6701 N. Charles Street | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | March 20, 1968 | | | | New Cathedral Cemetery | | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| J. E. Lowell Lemmon | | | | DATE | | | | MAR 20 1968 | | | | | | | |
| 4611 Park Heights Ave. | | | | | | | | | | | | | | | |

03611

RECEIVED CHARGE

03630

DO NOT WRITE ON THIS

UNITED STATES GOVERNMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|---|---|--|--|---|---|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 03691 | | | | | | | | | | | |
| 03672 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Thornton | | | W. Fowler | | | Month 3 Day 31 Year 68 | | | M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| male | | white | | Dec. 21, 1893 | | | 74 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Md. | | U. S. | | | | Baltimore Md. | | | | | |
| 1d. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | fitter | | | sprinklerCo | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | | | Balto. | | | | 309 S. Mount Street | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Howard Fowler | | | Sadie Williams | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| No | | | 212-07-5278A | | Records: SPRING GROVE STATE HOSPITAL | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PNEUMONIA | | | | | | | | | 4 days- | | |
| 4290 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) CONGESTIVE Heart Failure | | | | | | | | | 1 week | | |
| DUE TO, OR AS A CONSEQUENCE OF
(c) CARDIAC ENLARGEMENT | | | | | | | | | UNKNOWN | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4344 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF DEATH
HOUR A.M. Month Day Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 6 P.M. 55 PM. 3-31-68 | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from March 22, 1968, to 3-31, 1968, that (I) (we) last
saw the deceased alive on 3-31-1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | 22c. DATE SIGNED | | |
| Ferdinand Massari M.D. DEGREE | | | | | | | | | 3-31-68 | | |
| 22d. PHYSICIAN'S
NAME (Type) FERDINAND MASSARI | | | | | 22e. ADDRESS | | | | | | |
| | | | | | SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 4/3/68 | | Loudon Park Cemetery | | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | |
| Walters Funeral Home Pratt & Stricker Sts. | | | | | DATE APR 2, 1968 | | | | | Charles Judge | |

03875

RECORDS OF DEATH

18350



RECEIVED
FEB 10 1900

RECEIVED
FEB 10 1900

State General Homeopathic Hospital
Lyon on Park Cemetery, Berkeley, California
1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M REV. 4-68

MEDICAL CERTIFICATION

| | | | | | |
|---|--|--|--|---|--|
| 03692 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 03673 | |
| 1. DECEASED-NAME (Type or print) First Middle Last
HYMAN FRADIN | | | | 2a. DATE OF DEATH Month Day Year
MARCH 8, 1968 | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
AUGUST 26, 1893 | |
| 6. AGE (In years last birthday)
74 YRS. | | 7. AGE (In years last birthday)
74 YRS. | | 8. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
RUSSIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
BALTIMORE | | 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3503 LYNHAVEN DRIVE | |
| 12a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE MARYLAND | | 12b. CITY OR TOWN
BALTIMORE | | 12c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13a. STREET AND NUMBER
3503 LYNHAVEN DRIVE | | 13b. CITY OR TOWN
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME First Middle Last
SAMUEL FRADIN | | 15. MOTHER'S MAIDEN NAME First Middle Last
ESTHER MARY ? | | 16. SOCIAL SECURITY NO.
4100 | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
NO | | 17b. SOCIAL SECURITY NO.
4100 | | 17. INFORMANT Address
MRS. ROSE FRADIN, 3503 LYNHAVEN DR. #7 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF <u>HASOWN</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>minutes</u>
<u>104</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/65</u> , 19 <u>65</u> , to <u>3/8/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/8/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Joseph Shear</u> | | 22c. DATE SIGNED
3/8/68 | | 22d. PHYSICIAN'S NAME (Type)
JOSEPH SHEAR | |
| 22e. ADDRESS
6715 PARK HEIGHTS AVENUE | | 22f. ADDRESS
6715 PARK HEIGHTS AVENUE | | 22g. ADDRESS
6715 PARK HEIGHTS AVENUE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-10-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BOBROISKER VEREIN | |
| 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | 23e. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | 23f. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |
| 24. FUNERAL DIRECTOR
SOL LEVINSON & BROS. 6010 REISTERSTOWN RD | | 24a. REC'D BY REGISTRAR
MAR 12 1968 | | 24b. REGISTRAR'S SIGNATURE
<u>Charles Jones</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03693

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03676

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Herman Otto Frederick | | | 2a. DATE OF DEATH
Month 3 Day 29 Year 68 | | | 2b. HOUR
6 A M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-24-1883 | | 6. AGE (In years last birthday)
84 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Balto. Md. | | 7b. CITIZEN, OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. Md. | |
| 10. CITY OR TOWN OF DEATH
Balto. Co. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
8414 Mennymount Drive | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Reppars Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
— | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
8414 Mennymount Drive | | 14. FATHER'S NAME
First Gustav Middle Frederick Last Frederick | | 15. MOTHER'S MAIDEN NAME
First Augusta Middle — Last ? | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
217-05-0057A | | 17. INFORMANT
Mrs. Johanna E. Frederick | | Address 8414 Mennymount Drive | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ① Unemia
185X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ② C.A. of prostate & metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) Sen | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
177X Senility - Chronic Brain Syndrome - | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-11-1967 , to 3-29-1968 , that (I) (we) lost saw the deceased alive on 3-29-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Cesar Valle Cervero | | | | DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-29-68 | |
| 22d. PHYSICIAN'S NAME (Type)
CESAR VALLE CAVERO | | | | 22e. ADDRESS
3629 Liberty Rd. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-1-68 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Pauls | | 23d. LOCATION (City or Town) (County) (State)
Violetville. Md. | |
| 24. FUNERAL DIRECTOR
Loring Byers - 8728 Liberty Road | | | | 25a. REC'D BY REGISTRAR
DATE APR 2 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

03693

MADE IN U.S.A.

03693



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03694 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03675 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|-----------------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last
MILTON FRIEND | | | | | | | | | | Month 3 Day 14 Year 68 | | | | | | | | | | 3:15A M | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years lost birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| M | | | | | Negro | | | | | 11. 26. 16 | | | | | 51 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | |
| Virginia | | | | | USA | | | | | | | | | | Baltimore County, Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Mount Wilson | | | | | Mount Wilson State Hosp. | | | | | Still worker | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | Baltimore | | | | | Baltimore | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 4 Fleming Drive | | | | | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
CHARLIE FRIEND | | | | | First Middle Last
ELIZABETH LOUIS | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| No | | | | | 213-09-0729 | | | | | Records, Mt. Wilson State Hospital | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 431.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 337X
DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL HEMORRHAGE
DUE TO, OR AS A CONSEQUENCE OF (c) EXTENSIVE ANTERIOR CEREBROVASCULAR DISEASE
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1) Pulmonary tuberculosis, active. 2) Pulmonary emphysema | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | HRS | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 5 DAYS | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | YRS | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7. 21. 1967, to 3. 14. 1968, that (I) (we) last saw the deceased alive on 3. 14. 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| W. Newcomer | | | | | | | | | | 3. 14. 68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| William Newcomer, M.D. | | | | | | | | | | Mount Wilson, Maryland | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 3-17-68 | | | | | Arbutus Mem. Park | | | | | Balto. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | |
| Morton E. Dyett F.H. | | | | | | | | | | 1701 Laurens St. | | | | | | | | | | DATE MAR 18 1968 | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03695 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03676 | | | | | | | | | |
|---|--|--|------------------------------|--|--|--|--|--|---------------------------------|---|--|-----------------------------|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| MARY E. Gerwig | | | | | | | | | | 3 22 68 | | | | | | | | | | 9 10 PM | | | | | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| Female | | | White | | | NOV 8, 1901 | | | 66 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Md. | | | U.S.A. | | | | | | Baltimore Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Catonsville, Md. | | | | | St. Ann's Nursing Home | | | | | Housewife | | | | | Home | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MARYLAND | | | | | Howard | | | | | West Friendship | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| Charles E. Thompson | | | | | Amanda - Davis | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| No | | | | | 214 22 5269 | | | | | Mrs. Jessie Ramsburg-West Friendship, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration, Uremia | | | | | | | | | | | | | | | DAYS | | | | | | | | | | | | | | |
| 203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myelomatous Kidney | | | | | | | | | | | | | | | 5 mo | | | | | | | | | | | | | | |
| (c) Multiple Myeloma | | | | | | | | | | | | | | | 5 mo | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 203X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1968, to 22 March 1968, that (I) (we) last saw the deceased alive on 22 March 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | |
| William S. Bryson | | | | | | | | | | | | | | | 22 March 68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| William S. BRYSON | | | | | | | | | | | | | | | 4605 Edmondson | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Burial | | | | | 3-26-68 | | | | | Mt View Cemetery | | | | | Howard Co. Md. | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |
| Harry W. Haight | | | | | Lykesville, Md. | | | | | MAP 29 1968 | | | | | Charles Judge | | | | | | | | | | | | | | |

47343

STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03696 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03677 | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | | First Middle Last | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | |
| MOLLY | | | | | GOLDSTEIN | | | | | MARCH 29, 1968 | | | | | 10:45 PM | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last birthday) | | | | | 7. YRS. | | | | | | | | | |
| FEMALE | | | | | WHITE | | | | | MARCH 22, 1890 | | | | | 78 | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | Md. | | | | | | | | | |
| RUSSIA | | | | | U.S.A. | | | | | | | | | | BALTIMORE | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| PIKESVILLE | | | | | MILFORD MANOR NURSING HOME | | | | | HOUSEWIFE | | | | | AT HOME | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b. COUNTY | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| MARYLAND | | | | | Harford | | | | | ABERDEEN | | | | | YES | | | | | 626 BURKLEY AVENUE | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First Middle Last | | | | | | | | | | | | | | |
| UNKNOWN | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT | | | | | Address | | | | | | | | | | | | | | |
| NO | | | | | 074-20-1114A | | | | | MR. FREDERICK T. GOLDSTEIN | | | | | 440 W. END AVE. NEW YORK, N.Y. 10024 | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart disease</u> | | | | | | | | | | | | | | | yrs. | | | | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| | | | | | 19 | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , 19 <u>66</u> , to <u>3/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Milton Kirsh</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED <u>3/30/68</u> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>MILTON KIRSH</u> | | | | | | | | | | | | | | | 22e. ADDRESS <u>4000 W. NORTHERN PARKWAY</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| REMOVAL-BURIAL | | | | | 3-30-68 | | | | | MT. ARAT | | | | | FARMINGDALE, LONG ISLAND, YORK NEW | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u> | | | | | | | | | | | | | | | 25a. REG. NO. <u>APR 3 - 1968</u> | | | | | REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | |

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DATE: 1958 10 10

TIME: 10 10

LOCATION: 10 10

REMARKS: 10 10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03697 | | | | | | | | | | | | 03676 | | | | | | | | | | | |
|--|--|--|---------------------|--|--|---|--|---|--|---|--|---|--|--|---|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) MARY GERTRUDE GOONAN | | | | | | 2a. DATE OF DEATH
Month MARCH Day 27 Year 68 | | | | | | 2b. HOUR
939P M | | | | | | | | | | | |
| 3. SEX
F | | | 4. RACE
W | | | 5. DATE OF BIRTH
5/13/1888 | | | | | | 6. AGE (In years last birthday)
79 YRS. | | | IF UNDER 1 YEAR
MONTHS 19 DAYS 19 HOURS 19 MIN. | | | IF UNDER 24 HRS.
HOURS 19 MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1906 EDENWOOD RD. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD. CITY BALTIMORE | | | | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
EDENWOOD RD. 1906 | | | | | | | | | | | |
| 14. FATHER'S NAME First TIMOTHY Middle GOONAN Last GOONAN | | | | | | 15. MOTHER'S MAIDEN NAME First HELEN Middle KANE Last KANE | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
213-54-3393 | | | | 17. INFORMANT Address
GILBERT STRICKER 1906 EDENWOOD RD. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
410.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF
(c) 70 YEARS | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
SUDDEN | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 19 Day 19 Year 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from AUG , 19 67 , to MARCH , 19 68 , that (I) (we) last saw the deceased alive on FEB. 17 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Samuel O'Mansky M.D. DEGREE MD. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | 22c. DATE SIGNED
MAR 24 68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) SAMUEL O'MANSKY | | | | | | | | 22e. ADDRESS
PS 23 LOCH KAVEN BLVD. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
3-27-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Walters Funeral Home Pratt & Stricker Sts. | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1968 | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | | | | |

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SEC-40-012

SECRET

CONFIDENTIAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1515 (4)
30M REV. 1/68

| 03698 | | | | | | | | | | | | 03679 | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--------------------------------|--|-----------------|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Mary</i> | | | | First <i>Mary</i> Middle <i>[REDACTED]</i> Last <i>GORDON</i> | | | | 2a. DATE OF DEATH
Month <i>3</i> Day <i>27</i> Year <i>1968</i> | | | | 2b. HOUR
<i>5:20 AM</i> | | | | | | | | | | | |
| 3. SEX
<i>Female</i> | | | | 4. RACE
<i>White</i> | | | | 5. DATE OF BIRTH
<i>8-28-1885</i> | | | | 6. AGE (In years last birthday)
<i>72</i> YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>London Eng.</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
<i>Baltimore County</i> | | | | Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balt. Md.</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Melford Manor nursing home</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>SECRETARY</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>GENERAL</i> | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE
<i>Maryland</i> | | | | 13b. COUNTY
<i>Baltimore</i> | | | | 13c. CITY OR TOWN
<i>BALTO</i> | | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
<i>Esplanade Apts</i> | | | | APT. <i>6</i> G | | | |
| 14. FATHER'S NAME
<i>Simon</i> | | | | First <i>Simon</i> Middle <i>[REDACTED]</i> Last <i>GORDON</i> | | | | 15. MOTHER'S MAIDEN NAME
<i>Yetta Steinberg</i> | | | | First <i>Yetta</i> Middle <i>[REDACTED]</i> Last <i>[REDACTED]</i> | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
<i>212-09-0594</i> | | | | 17. INFORMANT
<i>MR. PAUL FORD</i> | | | | Address
<i>1008 ROBROY DRIVE, SILVER SPRING, MD. 20903</i> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Thrombotic myocardial infarction. Cardiac failure. 1830</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <i>Popliteal aneurysm. Aortic aneurysm. May 10, 1967.</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Generalized pericardial and renal tubular necrosis.</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>None.</i> | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>May 67.</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<i>May 10-1967</i> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<i>Popliteal aneurysm. Aortic aneurysm.</i> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>June</i> , 1967, to <i>March 27, 1968</i> , that (I) (we) last saw the deceased alive on <i>March 26</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Bernard J. Cohen MD</i> | | | | | | | | | | | | 22c. DATE SIGNED
<i>3/27/68</i> | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>DR. BERNARD J. COHEN.</i> | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>BURIAL</i> | | | | 23b. DATE
<i>3-28-68</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>BNAI ISRAEL</i> | | | | 23d. LOCATION (City or Town) (County) (State)
<i>BALTIMORE, MARYLAND</i> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Ed Levinson</i> | | | | 6010 REISTERSTOWN ROAD
<i>Ed Levinson & BROS. INC.</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>MAR 29 1968</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 03699 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | 03680 | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--------------------------------|--|--|--|----------|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | | | 2b. HOUR | | | | | | | | | | | |
| First Middle Last
VERONICA G. GRAY | | | | | | | | | | | | Month Day Year
MARCH 31 1968 | | | | | | | | | | | | 8:45 PM | | | | | | | | | | | |
| 3. SEX
F | | | | 4. RACE
W | | | | 5. DATE OF BIRTH
FEB. 7, 1913 | | | | 6. AGE (In years lost birthday)
55 YRS. | | | | IF UNDER 1 YEAR
MONTHS DAYS | | | | IF UNDER 24 HRS.
HOURS MIN. | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MINN. | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
BALTIMORE | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
RANDALLS TOWN | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7208 OAK HAVEN RD. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HOUSEKEEPER | | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | | 13b. COUNTY
BALTO. | | | | 13c. CITY OR TOWN
RANDALLSTOWN | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET AND NUMBER
7208 OAK HAVEN RD. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last
EUGENE GRIMES | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ROSE MUNTRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | | | 16b. SOCIAL SECURITY NO.
— | | | | 17. INFORMANT
Leland W. Gray | | | | Address
7208 OAK HAVEN RD. | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>General Carcinomatosis</u>
<u>174X</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>Carcinoma Rep breast 1966</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>Rebreast 1967</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 month</u> | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>170X</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> , 19 <u>57</u> , to <u>3/31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Eliot W. Johnson</u> | | | | | | | | | | | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Eliot W. Johnson</u> | | | | | | | | | | | | 22e. ADDRESS
<u>3432 Sandstone Ave
Baltimore Md 21229</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE
<u>4-4-68</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lakeview Cem.</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Carroll Md.</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Foley-Cronan & F.H. - Catonsville Ave</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>APR 9 - 1968</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| 03700 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03681 | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|------------------------------|--|--|--|--|--|--|--|--|--|---------------------------------|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | |
| First Middle Last
Merrill J. Green | | | | | | | | | | Month Day Year
March 31, 1968 | | | | | | | | | | 12:15 P.M. | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | 4. RACE | | | | | 5. DATE OF BIRTH | | | | | 6. AGE (In years last-birthday) | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | | | | | | |
| male | | | | | white | | | | | July 4, 1921 | | | | | 46 YRS. | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | USA | | | | | | | | | | Baltimore County Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Towson | | | | | | | | | | Dulaney-Towson N. H. | | | | | | | | | | Plant Superintendent-Mont. Ware | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | | | | | | Baltimore | | | | | | | | | | Parkville | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 7718 Wilson Ave. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Frank D. Green | | | | | | | | | | Dora V. Gilbert | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give year or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| yes | | | | | | | | | | WW 2 | | | | | | | | | | 218091713 | | | | | | | | | | Anne K. Green same | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 276x | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | 2891 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 26, 1967, to March 9, 1968, that (I) (we) last saw the deceased alive on December 4, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Francis T. Daly MD DEGREE | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 4/1/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Francis T. DALY | | | | | | | | | | 22e. ADDRESS 3201 N. Charles St | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE 4-3-68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem. | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Leonard J. Ruck, Inc Baltimore, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR APR 1 - 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

03681

RECORDS OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

03682

| | | | | |
|---|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) CECILIA GREIL | | 2a. DATE OF DEATH
Month March Day 10 Year 1968 | | 2b. HOUR
1:40A |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
November 4, 1888 | 6. AGE (In years lost birthday)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson 21204 | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
retired Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
6116 Belair Rd. -21206 |
| 14. FATHER'S NAME
First Frank Middle Groil Last Groil | 15. MOTHER'S MAIDEN NAME First Petronilla Middle Propst Last Propst | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.
212-07-76706A | 17. INFORMANT
Address
Mrs. Theresa Brady, 4107 Westmeath Rd. #36 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypovolemic shock
5301
DUE TO, OR AS A CONSEQUENCE OF
(b) Acute hemorrhage
DUE TO, OR AS A CONSEQUENCE OF
(c) Ulceration of esophagus
Laceration of esophagus, with perforation | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5391 | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9th , 19 68 , to March 10th 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 10th , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. Natural causes | | | | |
| 22b. SIGNATURE
Reynaldo Orjeula-Gomez, M.D. | 22c. DATE SIGNED
3/10/68 | 22d. PHYSICIAN'S NAME (Type)
Reynaldo Orjeula-Gomez, M.D. | | |
| 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
3/13/68 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Baltimore, Md. 21214 | 25a. REC'D BY REGISTRAR
DATE MAR 11 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03702 | | | | | | | | | | 03683 | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | |
| First Middle Last
JOHN EDWARD GRIEBEL | | | | | | | | | | Month Day Year
MARCH 3, 1968 | | | | | | | | | |
| 3. SEX | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| MALE | | | | | | | | | | M | | | | | | | | | |
| 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | |
| WHITE | | | | | | | | | | 6/6/96 | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | |
| Baltimore | | | | | | | | | | 71 YRS. | | | | | | | | | |
| 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | |
| U.S.A. | | | | | | | | | | BALTIMORE Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | |
| FORT HOWARD | | | | | | | | | | VETERANS ADMIN. HOSPITAL | | | | | | | | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| LABORER | | | | | | | | | | CONSTRUCTION | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | |
| MARYLAND | | | | | | | | | | SEVERNA PARK | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| JOHN GRIEBEL | | | | | | | | | | ANNA FISHER | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | |
| YES WWI | | | | | | | | | | 213 16 16 37 | | | | | | | | | |
| 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | |
| CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE HEART FAILURE | | | | | | | | | | HOURS | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | | | | | | | ABCESSES, PROSTATE, LT. KIDNEY, LUNGS | | | | | | | | | |
| | | | | | | | | | | DAYS | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| | | | | | | | | | | SEPTICEMIA, STAPHYLOCOCCUS AUREUS | | | | | | | | | |
| | | | | | | | | | | DAYS | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| HCVD; AORTIC ANEURYSM; ARTERIOLAR NEPHROSCLEROSIS | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | |
| 053.1 | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| YES | | | | | | | | | | NO | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | |
| <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | HOUR A.M. Month Day Year
P.M. 19 | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from FEB 23 , 19 68 , to MAR 3 , 19 68 , that (we) last saw the deceased alive on MAR 3 , 19 68 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | |
| Neilson Neilson, M.D. | | | | | | | | | | 3/3/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| NEILSON, NEILSON | | | | | | | | | | VAH, FT. HOWARD, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | |
| BURIAL | | | | | | | | | | 3-6-68 | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| LOUDAN PARK CEMETERY | | | | | | | | | | BALTIMORE, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | |
| BARRANCO FUNERAL HOME, SEVERNA PARK, MD. | | | | | | | | | | 7 1968 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Robert J. Barranco | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M. REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|---|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) BABY BOY GROSS | | | First Middle Last | | | 2a. DATE OF DEATH
Month 3 Day 2 Year 68 | | | 2b. HOUR
10 A M |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
3-1-68 | | 6. AGE (In years last birthday)
YRS. MONTHS DAYS | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Co. Md. | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Balto. Med. Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | | 13b. COUNTY
Balto. Co. | | 13c. CITY OR TOWN
PIKESVILLE | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1300 ROBIN ROAD |
| 14. FATHER'S NAME
First Middle Last
MILFORD ST. CLAIR GROSS | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
LAUGEKE MAN BEST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
NO | | | 16b. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
DABIES CHART | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
7762
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Immaturity
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 minutes
12 hours | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
7735 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 68 , to 3-2 , 19 68 , that (I) (we) lost the deceased alive on 3-2 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. HANCOCKSON MD | | | | | | 22c. DATE SIGNED
3/2/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
cremation | | | 23b. DATE
3/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY
GBMC | | 23d. LOCATION (City or Town) (County) (State)
Towson, Balto. Md. | | |
| 24. FUNERAL DIRECTOR
John E. Adams, M.D. GBMC | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 5 1968 | | 25b. REGISTRAR'S SIGNATURE
John E. Adams | |

03368

03368

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Eleanor P. Guthrie | | | | | | 2a. DATE OF DEATH
Month March Day 25 Year 1968 | | | 2b. HOUR M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1/22/13 | | | 6. AGE (In years lost birthday)
55 YRS. | | IF UNDER 1 YEAR
MONTHS 55 DAYS 55 HOURS 55 MIN. | | IF UNDER 24 HRS.
HOURS 55 MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Spring Grove State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
Pa. Maryland | | | 13b. CITY OR TOWN
Relay | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER
113 W. Mounty Airy Ave. | | | |
| 14. FATHER'S NAME First Joseph Middle Price Last Price | | | | 15. MOTHER'S MAIDEN NAME First Elizabeth Middle Tuttle Last Tuttle | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
Yes, no, or (unknown) | | | | 16b. SOCIAL SECURITY NO.
191-36-6981 | | 17. INFORMANT Address
Records: Spring Grove State Hospital | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
309.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 309.9
(b) _____ DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Chronic Brain Syndrome with disease of brain - Encephalitis | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year 19
P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 15 , 19 65 , to March 25 , 19 68 , that (I) (we) last saw the deceased alive on March 25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
NARCISO W. CHARMONA M.D. DEGREE _____ ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE, SIGNED
3/25/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
NARCISO W. CHARMONA | | 22e. ADDRESS
Spring Grove State Hospital | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
3/27/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlands Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Bryn Mawr, Pa. | | | | | |
| 24. FUNERAL DIRECTOR
Wm. J. Tichner & Sons ADDRESS Baltimore, Md. | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

03705

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03686

| | | | | | | | | | | |
|---|--|--|---|---|--|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Hubertha E. Haas</i> | | | 2a. DATE OF DEATH
Month <i>9</i> Day <i>17</i> Year <i>1968</i> | | | 2b. HOUR
<i>6:45</i> AM | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>Cau</i> | | 5. DATE OF BIRTH
<i>4-1-1883</i> | | 6. AGE (In years lost birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Balto., Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Balto. County</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Balto., Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)
<i>GBMC</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
<i>Na</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Na</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Balto.</i> | | 13c. CITY OR TOWN
<i>Balto.</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>6014 Shadyspring Ave.</i> | |
| 14. FATHER'S NAME First Middle Last
<i>Emerson R. Scherer</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>CAROLINE W. K. Hout GREBE</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <i>Unknown</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
<i>213-48-7130</i> | | 17. INFORMANT
<i>Chart</i> Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
<i>4319</i>
IMMEDIATE CAUSE (a) <i>Respiratory distress due to aspiration pneumonia 4 wks.</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Cerebral hemorrhage - stroke</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>(R) hemiplegia</i> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>332x</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-26-</i> , 19 <i>68</i> , to <i>3-17-</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>3-17-</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Nasser Eftekhar</i> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>3/17/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>NASSER EFTEKHARI</i> | | | | | 22e. ADDRESS
<i>GBMC BALT. MD. #4.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
<i>MAR 19 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>HOLY REDEEMER CEM</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>4438 BELAIR RD MD</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>THE DIPPEL BROS INC 7110 BELAIR RD</i> | | | | | 25a. REC'D BY REGISTRAR
<i>MAR 20 1968</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. ...</i> | | | |

03709

03688

CENTRAL OF DEATH

Responsible for the death of a person
in the Central of Death - 1912
R. H. H. H.



3-17-12

WASHER EPTKHAZI

GRAND BUILT MD #1

1 3/17/12

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--------------------------------|---|--------------------------------|---|----------------------------|----------------------|--|
| 1. DECEASED-NAME (Type or print) | | First
JOHN | | Middle
HOWARD | | Last
HALE | | SR | | 2a. DATE OF DEATH
Month Day Year
MARCH 19 1968 | | | 2b. HOUR
3:30A M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
7/20/16 | | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CHAUFFEUR | | 12b. KIND OF BUSINESS OR INDUSTRY
AIRPORT | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
2500 BROHAWN AVENUE 21230 | | | | | | | |
| 14. FATHER'S NAME | | First
HOWARD | | Middle
GEORGE | | Last
HALE | | 15. MOTHER'S MAIDEN NAME | | First
JUANITA | | Middle
MN | | Last
YOUNG | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
YES | | 16b. SOCIAL SECURITY NO.
WW 11 212 10 61 61 | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE MONOCYTIC LEUKEMIA
206.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 204.2
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 MONTHS | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
BRONCHOPNEUMONIA | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (he) (this hospital) attended the deceased from 1/8/68 , 19____, to 3/19/68 , 19____, that (he) (we) lost saw the deceased alive on 3/19/68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Peter V. Juwan</i> | | DEGREE | | ATTENDING PHYS. | | <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. | | 22c. DATE SIGNED
3/19/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
PETER V. JUVAN, M. D. | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LOUDEN PARK NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard | | ADDRESS
HUBBARD FUNERAL HOME | | DATE
MAR 21 1968 | | 25a. REC'D BY REGISTRAR
25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |
| | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03707 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03688 | | | |
|--|--|---|--|---|--|--|--|---|--|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
RUTH | | Middle
C. | | Last
HALLER | | 2a. DATE OF DEATH
March Month 9, Day 1968 Year | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 21, 1920 | | 6. AGE (In years
last birthday)
47 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Arbutus | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
1238 Leeds Terrace | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Arbutus | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1238 Leeds Terrace | | | |
| 14. FATHER'S NAME
First Middle Last
Arthur Boswell | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Amelia Brandenburg | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
Yes, na, or (unknown) | | | | | | | |
| 16b. SOCIAL SECURITY NO.
216-16-4378 | | 17. INFORMANT
Address
21227
Mr. Edward W. Haller, 1238 Leeds Terrace | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA of BREAST</u>
174X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTASIS TO LUNG & SPINE</u>
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>CMD</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
170X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9 March 1968</u> , to <u>10 March 1968</u> , that (I) (we) lost
saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>George E. Groleau</u> | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>10 March 68</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. George E. Groleau | | 22e. ADDRESS
5608 Main Street, Elkridge, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | 23b. DATE
3-13-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE <u>11 11 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>William J. Jones</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---|--|--|-----------------------------|--|--|--------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
William | | | Middle
C. | | | Last
Harple | | | 2a. DATE OF DEATH
Month
3 | | | Day
8 | | | Year
1968 | | | 2b. HOUR
8:00 PM | | |
| 3. SEX
Female | | | 4. RACE
Cau. | | | 5. DATE OF BIRTH
12-29-1890 | | | 6. AGE (In years
last birthday)
77 | | | IF UNDER 1 YEAR
MONTHS | | | IF UNDER 24 HRS.
DAYS | | | IF UNDER 24 HRS.
HOURS | | | IF UNDER 24 HRS.
MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto. Md. | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Parkville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Housewife | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | | 13b. COUNTY
BALTO | | | 13c. CITY OR TOWN
Parkville | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
1818 Forrest Road 21234 | | | | | | | | | | | |
| 14. FATHER'S NAME
First
Paul | | | Middle
Gals | | | Last
Gals | | | 15. MOTHER'S MAIDEN NAME
First
Fannie | | | Middle
Unverzagt | | | Last
Unverzagt | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
No | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
216-10-11280 | | | 17. INFORMANT
Mrs Viola Grimm 1819 Forrest Road 21234 | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rheumatoid Arthritis - advanced
4129 DUE TO, OR AS A CONSEQUENCE OF Severe
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bacterial pneumonia
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis (Heart Disease)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4200 Fractured long bones | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1960, to Mar 8, 1968, that (I) (we) last saw the deceased alive on Mar 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | 22b. SIGNATURE
Donald W. Montz | | | 22c. DATE SIGNED
3/10/68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
DONALD W. MONTZ | | | 22e. ADDRESS
3009 EVERGREEN AVE BALTO | | | 22f. ADDRESS | | | 22g. ADDRESS | | | 22h. ADDRESS | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
3-11-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Western Cemetery | | | 23d. LOCATION (City or Town)
Baltimore | | | 23e. LOCATION (County)
Co. Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Lorraine Funeral Home 7401 Blair Road | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE MAR 12 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | | | 25c. REGISTRAR'S SIGNATURE | | | | | | | | | | | |

03700

CERTIFICATE OF DEATH

03700

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEPARTMENT OF HEALTH, CITY OF NEW YORK, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--------|---|---|--|---|---|--------------------------|--|------|
| 1. DECEASED-NAME
(Type or print) Vinnie | | First | Middle | Last | 2a. DATE OF DEATH
Month 3 Day 9 Year 68 | | 2b. HOUR
9:35 P M | | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
June 27, 1879 | | 6. AGE (In years
last birthday)
88 YRS. | | IF UNDER 1 YEAR
MONTHS | IF UNDER 24 HRS.
DAYS | HOURS | MIN. |
| 7a. BIRTHPLACE (State or foreign
country) Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
SPRING GROVE STATE HOSP. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN
Suitland | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4801 Meadow View Dr. | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| | | Thompson | | | | | Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
219-54-3153J | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Heart failure
486x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) Bed ridden | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
days
days
year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
493x old age | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 7, 1960 , to March 9, 1968 , that (I) (we) last
saw the deceased alive on March 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Narciso Aristigueta | | M.D. DEGREE | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-9-68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) NARCISO ARISTIGUETA | | 22e. ADDRESS SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
3-12-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) | | (County) | (State) | | |
| Burial | | | | | | Suitland | | Maryland | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home
4308 Suitland Road Suitland Maryland | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 13 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

12320

COMMISSION OF DEATH

02709

Department of Health

1-10-17-1772

REPORT OF DEATH

1-10-17-1772

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03710

03632

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) ANNA DENSON HATCHER | | | 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
Oct. 6, 1879 | | | 6. AGE (In years last birthday)
88 YRS. | | | 7a. BIRTHPLACE (State or foreign country)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Baptist Home of Md. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | | | 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
3824 Tudor Arms Ave. | | |
| 14. FATHER'S NAME First Middle Last
Richard Denson | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Graville | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
174-01-0755 A | | | 17. INFORMANT Address
Baptist Home of Md. Owings Mills, Md. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apoplexy & anemia
4369
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) arteriosclerotic cerebrovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) senility
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
334X | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1965, to April 21, 1966, that (I) (we) last saw the deceased alive on April 21, 1966, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE Dr. Paul M. Byerly DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 8/22/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Paul M. Byerly | | | 22e. ADDRESS 5820 York Rd. Baltimore, Md. | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | 23b. DATE 3-23-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount | | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home, Inc. ADDRESS 6500 York Rd. Baltimore, Md. 12121 | | | 25a. REG'D BY REGISTRAR MAN 28 1968 DATE | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

3
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03711
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
03693

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Harry | | First
Harry | | Middle
W. | | Last
Hazelip | | 2a. DATE OF DEATH
Month March Day 10 Year 68 | | | 2b. HOUR
5:30 M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
12-6-04 03. | | | 6. AGE (In years last birthday)
64 YRS. | | IF UNDER 1 YEAR
MONTHS 64 DAYS 35 | | IF UNDER 24 HRS.
HOURS 64 MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
Retired Auto Dealer | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
STATE Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
4708 Harford Rd. | | | | |
| 14. FATHER'S NAME
First Edwin Middle Hazelip Last Hazelip | | 15. MOTHER'S MAIDEN NAME
First Margaret Middle ? Last ? | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
218-32-0746 | | 17. INFORMANT
Address Mrs. Sarah R. Hazelip (Same) | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema
4120
DUE TO, OR AS A CONSEQUENCE OF
(b) hypertensive arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Uremia and anemia due to benign nephrosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
443X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. 19 Month 19 Day 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. Na. County State | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 3-9-68 , 19 68 , to 3-10- , 19 68 , that (X) (we) last saw the deceased alive on 3-10- , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Illia | | DEGREE Attending PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 11, 1968 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/14/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Parkwood Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAR 12 1968 | | 25b. REGISTRAR'S SIGNATURE
John J. Judge | | | | | | |

ATSG

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Figure 2

Approved: J. Frank, Inc. 10/10/50. 3/25/51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
304 REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. DECEASED-NAME
(Type or print) | | 2a. DATE OF DEATH | |
| First Middle Last
JOHN G HEIGER | | Month Day Year
March 31 1968 | |
| 3. SEX
M | | 2b. HOUR
1 A M | |
| 4. RACE
W | | 5. DATE OF BIRTH
Jan 31 1879 | |
| 6. AGE (In years last birthday)
89 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
USA | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Parkville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
2914 Cub Hill Rd. | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Steel | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Balto | |
| 13c. CITY OR TOWN
Parkville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
2914 Cub Hill Rd | | | |
| 14. FATHER'S NAME
First Middle Last
William Heiger | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Dorothea Kohler | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or (unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
213-07-9012 | |
| 17. INFORMANT
Address
Family records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular disease</u>
4129 DUE TO, OR AS A CONSEQUENCE OF <u>with myocardial degeneration</u>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 <u>Myocardial infarction old</u> | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mar 26</u> , 1968, to <u>Mar 31</u> , 1968, and that (I) (we) last saw the deceased alive on <u>Mar 31</u> , 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (and) did not view the body after death. | | | |
| 22b. SIGNATURE
<u>Frank T. Kasik</u> | | 22c. DATE SIGNED
4/2/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Frank T. Kasik M.D. | | 22e. ADDRESS
9005 Harford road | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-3/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Oaklawn Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Md. | |
| 24. FUNERAL DIRECTOR
ADDRESS
C.F. EVANS & SON 8802 Harford road | | 25a. REC'D BY REGISTRAR
DATE APR 8 - 1968 | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03713 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03695 | | | |
|---|--|--|--|--|--|--|--|------------------------|--|------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| First Edgar E. Middle Last Henley | | | | 3 Month 10 Day 68 Year | | | | 10 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | White | | 8-06-98 | | 67 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Md | | USA | | | | Baltimore Co. Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Catonsville | | Harvard Home | | Operator - Over Station - Transit | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md | | A A | | Baltimore | | NO | | Royal Beach | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| First Edgar E. Middle Last Henley | | First Nellie Tillow Middle Last | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| No | | 213059045 | | John Henley | | Cummingsville Rd | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ① Intractable Congestive Heart Failure | | | | | | | | | | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) ② Arteriosclerotic CV Disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) ③ Generalized Arteriosclerosis | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Urinary Incontinence - Urinary Infection - Parkinson's | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov 1, 197, to March 9, 1968, that (I) (we) lost saw the deceased alive on March 8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| Cesar Valle Cervero | | 3-11-68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| CESAR VALLE CAVERO | | 8629 Liberty Rd | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 3-13-68 | | Baltimore National | | Baltimore | | Md | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Robert A. Bananas | | Severna Park | | DATE MAR 14 1968 | | Charles J. J... | | | | | |

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U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, Pages 1 and 2 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|---------|--|------------------|---|---|--|--|------------------------|--------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | |
| NED | | G. | | HESS | MARCH 9, 1968 | | 8:30 PM | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| MALE | WHITE | | DEC. 18, 1901 | | 66 YRS. | | IF UNDER 24 HRS.
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| BALTIMORE, MD. | | U.S.A. | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| | | PROFESSIONAL HOUSE | | SHOES | | RETAIL | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | BALTIMORE | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 7705 CROSSLAND ROAD | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| ISAAC | | S. | | HESS | SELMA | | | | EISMAN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | 212-09-4468A | | MRS. MINDA HESS, | | 7705 CROSSLAND ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>
<u>4369</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) <u>Cerebral arteriosclerosis, severe</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 days</u>
<u>5 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>331X</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>67</u> , to <u>3/9</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/9</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Louis H. Schaffer, MD</u> DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>3/10/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
LOUIS SCHAFER | | | | | 22e. ADDRESS
222 W. COLD SPRING LANE | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 3-11-68 | | DRUID RIDGE | | BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN | | | | | 25a. REC'D BY REGISTRAR
DATE
MAR 12 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. [Signature]</u> | | |

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RECEIVED

031134

DATE: 11-11-62
TIME: 11:00 AM
FROM: B. A. A.
TO: B. A. A.

PROFESSIONAL BOARD
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03715

CERTIFICATE OF DEATH

03697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Pikesville</u> | | c. LENGTH OF STAY IN 1b
<u>Lifetime</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pikesville 8, Md.</u> | | d. STREET ADDRESS
<u>302 Reisterstown Rd., Pikesville 8, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>302 Reisterstown Rd., Pikesville 8, Md.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>George Cleveland Hesson</u> | | 4. DATE OF DEATH
Month <u>March</u> Day <u>6</u> Year <u>1968</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 27 1893</u> |
| 9. AGE (In years last birthday)
<u>75</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanic retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Self-employed</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Carroll County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William Hesson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah E. Ludwig</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mrs. Eva M. Hesson, 302 Reisterstown Rd.</u> | | Address <u>Pikesville 8, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4129 Anterovascular heart disease</u>
DUE TO (b) <u>few years</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u>
DUE TO (b) <u> </u>
DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>4200</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>58</u> , to <u>Mar 6</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Mar 1</u> 19 <u>68</u> , and that death occurred at <u>7:45</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Paul H Royse</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Paul H Royse</u> | | 22d. ADDRESS
<u>1403 Foley Lane Pikesville Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>March 9, 1968</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Druid Ridge Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Pikesville Baltimore, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Frank H. Howell Pikesville 8, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 8 1968</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
30M REV. 1/68

MD. DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03716

03698

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print)
Grace May Hines | | First Middle Last | | 2a. DATE OF DEATH
Month 3 , Day 1968 Year | | 2b. HOUR
6:35 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
May 29, 1888 | | 6. AGE (In years lost-birthday)
79 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Presbyterian Home of Md. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MD. | | 13b. COUNTY
BALTO. | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3707 GREENMOUNT AVE. | |
| 14. FATHER'S NAME
A.J. Hines | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Sarah E. Owens | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
215-10-2036 | | 17. INFORMANT
A Presbyterian Home of Md. Towson | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL Thrombosis -
2509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 hrs
YRS
YRS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
260X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 1, 1968 to MAR. 3, 1968 , that (I) (we) last saw the deceased alive on FEB. 28, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Attending MD. | | DEGREE ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-4-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Dr. S.J. Venable, Jr | | 22e. ADDRESS
7215 York Rd. Baltimore, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-6-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION (City or Town) (County) (State)
Woodlawn, Maryland | |
| 24. FUNERAL DIRECTOR
Mitchell-Wiedefeld Home, Inc. | | ADDRESS
6500 York Rd. Baltimore, Md. 21212 | | 25a. REC'D BY REGISTRAR
DATE MAR 8 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|---|---------|--|------------------|---|-------------------------------------|--|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | | |
| Anna | | Gera | Hoffmeister | March 1, 1968 | | | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| F | W | | 8/9/1901 | | 66 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Hungary | | U. S. A. | | Baltimore | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Towson | | Dulaney Towson Nursing Home | | Homemaker | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Balto. | | Balto. 21210 | | | | 30 Over Ridge Court | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| John | | Anna | | No | | | | Mrs. Helen H. Fingles, 324 Hawthorne Rd. 21210 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Decompensative Rheumatic Cardio Vascular Disease</u>
398 X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Left Hemiplegia from Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
416 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 16, 1966, to March 1, 1968, that (I) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Laurence C. Post M.D. | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/2/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Dr. Laurence C. Post | | 6805 York Road | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/4/68 | | Zion Evangelical Lutheran | | Stemmers Run, Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| H. W. Jenkins & Sons Co. | | 4905 York Road Balto. Md. 21212 | | MAR 5 1968 | | Charles Judge | | | |

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CERTIFICATE OF DEATH

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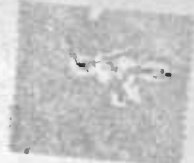
| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
LEO | | First
B. | | Middle
HOLLEIN | | Last | | 2a. DATE OF DEATH
Month MARCH Day 21 Year 1968 | | | | 2b. HOUR
2:05 ^A M | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
OCTOBER 13, 1915 | | | | 6. AGE (In years last birthday)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Procurement | | | | 12b. KIND OF BUSINESS OR INDUSTRY
MARTIN CO. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
1453 PUTTY HILL AVE. #21204 | | | | | |
| 14. FATHER'S NAME First Middle Last
Adolph Hollein | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Catherine Kubsie 1453 Putty Hill Av | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) WW II 1944 1945 | | | | | |
| 16b. SOCIAL SECURITY NO.
206 033 4434 | | | | 17. INFORMANT Marguerite
Mrs. Marguerite Hollein | | | | Address 21204 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 17 , 19 68 , to MARCH 21 , 19 68 , that (I) (we) last saw the deceased alive on MARCH 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Ismael Jamora DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
MARCH 21, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
ISMAEL JAMORA, M.D. | | | | | | | | 22e. ADDRESS
7620 YORK ROAD TOWSON, MD. #21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3-23-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Val. Mem. Garden Cem. | | | | 23d. LOCATION (City or Town) (County) (State)
Balto. Co. Maryland | | | | | |
| 24. FUNERAL DIRECTOR
Wm. E. Johnson, 8521 Loch Raven Blvd. 21204 | | | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03701

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Parkville</u> | | c. LENGTH OF STAY IN 1b
<u>overnight</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>3026 Moreland Ave Balto 36</u> | | d. STREET ADDRESS
<u>Kingsville Md</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>GEORGE MACOLM HOOPER</u> | | 4. DATE OF DEATH
Month <u>Mar</u> Day <u>21</u> Year <u>1968</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4-10-86</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Ret. Road Inspector Balto. Co.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Maryland</u> | 9. AGE (In years last birthday)
<u>81</u> yrs. |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO.
<u>213-05-8928 A</u> | |
| 17. INFORMANT
<u>Jane J. Everhart</u> | | Address
<u>3026 Moreland Ave. Balto.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardiovascular</u>
<u>4129</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dementia</u>
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>undet</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>4221</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>J. C. Hyle</u> | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>7527 Belton Rd</u> | |
| 23a. BURIAL, CREMATION, or other disposition
<u>Burial</u> | 23b. DATE THEREOF
<u>3/23/68</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Balto. Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Leonard J. Ruck Inc. Balto. Md.</u> | | 25a. RECEIVED BY REGISTRAR
DATE <u>MAR 22 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

03719

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[Faint, mostly illegible handwritten text]

Mr. Fred Thompson, Baltimore, Md.

Very truly,
Yours

U.S.A.

210-08-0920 A Lane 1, Apartment 3020, Maryland Ave., Baltimore, Md.

to

[Faint, mostly illegible handwritten text]

[Faint, mostly illegible handwritten text]

Edward J. Brock, Inc., Baltimore, Md.

New Catholicism, Baltimore, Md.

Baltimore, Md.

Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> 03720 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03702 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|-----------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
ANDREW | | | Middle
JAMES | | | Last
HOPPER , SR | | | 2a. DATE OF DEATH
Month 3 Day 26 Year 68 | | | 2b. HOUR
4:50A M | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
5/4/90 | | | 6. AGE (In years last birthday)
77 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 HRS.
HOURS
MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
NEW JERSEY | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADMINISTRATION HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
BROKER | | | 12b. KIND OF BUSINESS OR INDUSTRY
REAL ESTATE | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
ANNE ARUNDEL | | | 13c. CITY OR TOWN
GLEN BURNIE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
1000 EDGERLY ROAD | | | | | |
| 14. FATHER'S NAME
First
ANDREW | | | Middle
EDWARD | | | Last
HOPPER | | | 15. MOTHER'S MAIDEN NAME
First
EVELYN | | | Middle
(unknown) | | | Last
(unknown) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give year or dates of service)
WW I | | | 16b. SOCIAL SECURITY NO.
220 03 14 12 | | | 17. INFORMANT
Address
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
5320
IMMEDIATE CAUSE (a) ACUTE HEMORRHAGE, MASSIVE
DUE TO, OR AS A CONSEQUENCE OF
(b) —
DUE TO, OR AS A CONSEQUENCE OF
5470
(c) EROSION OF ARTERY, DUODENAL ULCER | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
HOURS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
CHRONIC BRAIN SYNDROME WITH CEREBRAL ARTERIOSCLEROSIS; ARTERIOSCLEROTIC HEART DISEASE. BENIGN PROSTATIC HYPERTROPHY | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/23/68 , 19__, to 3/26/68 , 19__, that (X) (we) lost saw the deceased alive on 3/26/68 , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Heilun Neilson, M.D. | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/26/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
NEILON NEILSON, M. D. | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3/29/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | | | 23d. LOCATION (City or Town) (County) (State)
GLEN BURNIE, MARYLAND | | | | | | | | |
| 24. FUNERAL DIRECTOR
E.B. Flannery | | | ADDRESS
SINGLETON FUNERAL HOME | | | 25a. RECD BY REGISTRAR
GLEN BURNIE, MARYLAND | | | 25b. REGISTRAR'S SIGNATURE
James J. Judge | | | | | | | | |
| DATE MAR 29 1968 | | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03721

CERTIFICATE OF DEATH

03703

| | | | | | | | |
|---|------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Catonsville</u> | | c. LENGTH OF STAY IN 1b
<u>4 months</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodlawn</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>House in the Pines Nursing Home</u> | | | | d. STREET ADDRESS
<u>5412 Gwynndale Avenue</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Kathleen C. Howard</u> | | | | 4. DATE OF DEATH
Month <u>March</u> Day <u>26</u> Year <u>1968</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | B. DATE OF BIRTH
<u>July 29, 1917</u> | | 9. AGE (In years last birthday)
<u>50</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Westminster Shoe Factory</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>John Tyson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Augusta Brown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or forces of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>215-16-9136</u> | | 17. INFORMANT
Address <u>Mrs. Ann Smith 5412 Gwynndale Avenue</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO <u>4129</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Chs. Atherosclerotic Cardio-Vascular Disease</u>
(c) <u>1 yr.</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>4221</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11-17, 1967</u> , to <u>3-26, 1968</u> , that (I) (we) last saw the deceased alive on <u>3-25-1968</u> , and that death occurred at <u>11:20 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Wilmer K. Gallagher</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>3-28-68</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Wilmer K. Gallagher, M.D.</u> | | | | 22d. ADDRESS
<u>6209 Frederick Ave. Baltimore, Md 21228</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>3/29/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Holy Cross Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Charles L. Stevens Funeral Home, Inc.</u>
<u>1501 EAST FORT AVENUE</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 28 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

03758

REPORT OF DEATH

03758

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03758

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(Type or print) THERLOW | | First Middle Last HUNTLEY | | 2a. DATE OF DEATH
Month MARCH Day 10 Year 1968 | | 2b. HOUR
3:55 AM | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
4-1-23 | | 6. AGE (In years last birthday)
44 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERANS ADMIN. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY
ALUMINUM | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1645 CHILTON STREET | |
| 14. FATHER'S NAME
First Middle Last
CULL HUNTLEY | | 15. MOTHER'S MAIDEN NAME
First Middle Last
CONNIE PARKER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
YES | | 16b. SOCIAL SECURITY NO.
WW II 245-28-2977 | | 17. INFORMANT
Address
CLINICAL RECORDS VAH, FORT HOWARD, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY EDEMA
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) MYOCARDITIS CHRONIC WITH MURAL THROMBI
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MONTHS
1 YEAR | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 BRONCHOPNEUMONIA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YES | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 7, 1968 , to MARCH 10, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 10, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
J. D. Talbert, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED
3/11/68 | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M.D. | | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
REMOVAL | | 23b. DATE
3/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY
PINEY GROVE | | 23d. LOCATION (City or Town) (County) (State)
PINEY GROVE N.C. | |
| 24. FUNERAL DIRECTOR
Locks Funeral Home | | | | 25a. REC'D BY REGISTRAR
MAR 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

40100

UNITED STATES OF AMERICA

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OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON

DEPARTMENT OF THE ARMY

OFFICE OF THE SECRETARY OF THE ARMY

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TO THE SECRETARY OF THE ARMY

FROM THE SECRETARY OF THE ARMY

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 6398
3/27/68 kk 03723
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03705

| | | | | | | | | |
|--|-------------------------|---|---|--|--|---|--|-----------------------------------|
| 1. DECEASED-NAME
(Type or Print) ROBERT WILLIAM HUTCHINGS | | | 2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> March 2 19 68 | | | 2b. HOUR 10 A M | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Nov. 19, 1896 | 6. AGE (In years last birthday)
71 68/RS | IF UNDER 1 YEAR
MONTHS 7 DAYS 68 | IF UNDER 24 HRS.
HOURS 9 MIN 45 | 2c. DATE PRONOUNCED DEAD
Month March Day 3 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country)
Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Village Truck Shop Rte. 40 - Pulaski Highway | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Dishwasher-truck stop | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
R. W. Hutchings | | | 15. MOTHER'S MAIDEN NAME
Zora Sebra | | | 17. INFORMANT ADDRESS
Mrs. Henry J. George White Stone, Va. | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
no | | | 16b. SOCIAL SECURITY NO.
unk. | | 17. INFORMANT ADDRESS
Mrs. Henry J. George White Stone, Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar Pneumonia
481X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
490X | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 19
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE
Werner U. Spitz | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
3/4/68 | | |
| EXAMINER'S NAME (Type)
Werner U. Spitz, M.D. | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | | 23b. DATE
3/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY
C Corrottoman Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Ottoman, Lancaster Va. | |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Hme 6500 York Rd. | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 8 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|--|--------|--|--------------------------|---|-------|----------------------------|----------|------------------|
| 03724 | | 03706 | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | Month | Day | Year | 2b. HOUR |
| John | | A. | Inglis | | March | | 9 | 1968 | | 3:30 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| M | | W | | 4/5/1888 | | 79 | | MONTHS | | DAYS |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Canada | | U. S. A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Towson | | St. Joseph's | | Traffic Manager-Freight | | West.Md.RR | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | | Baltimore | | | | 4118 Westview Road | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| William | | | Inglis | | Mrs. Dorothy A. Inglis | | | | Grossert | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| Yes | | WWT | | 705-10-4524 | | Mrs. Dorothy A. Inglis | | (Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 | | DUE TO, OR AS A CONSEQUENCE OF (b) Acute Respiratory Infection | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 1 day | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500 | | DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Artery Thrombosis | | | | 5 yrs. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | Ca of Mes. State | | | | 10 yrs. | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 3/9, 1968, that (I) (we) last saw the deceased alive on 3/6/68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3/9/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | Dr. Walter E. Karagin | | 22e. ADDRESS | | 4331 Harford Road | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 3/12/68 | | Baltimore | | Baltimore | | | | Md. |
| 24. FUNERAL DIRECTOR | | H. W. Jenkins & Sons Co. | | 4905 York Road Baltimore, Md. 21212 | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| VR A (5-4) 30M REV 11-68 | | | | | | DATE MAR 11 1968 | | J. Charles Judge | | |

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MDARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03725

CERTIFICATE OF DEATH

03707

| | | | | | | | | | | | |
|--|--|---|-----------------|---|--|---|---|--|----------------|---|--|
| 1. DECEASED NAME
(Type or print) | | First
Andrew | Middle
Smith | Last
Jackson | 2a. DATE OF DEATH
Month
March | | Day
20 | Year
1968 | 2b. HOUR
5A | M | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
10/27/1880 | | 6. AGE (In years
lost birthday)
87 | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto., Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Dulaney Towson N. H. | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Retired-Salesman | | 12b. KIND OF BUSINESS OR
INDUSTRY
Continental Can | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. 21212 | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
210 N. Tyrone Road Co. | | | |
| 14. FATHER'S NAME
First
Joseph | | Middle
Jackson | | Last
Dimand | | 15. MOTHER'S MAIDEN NAME
First
Jane | | Middle
Dimand | | Last
Dimand | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
212-03-4566 | | 17. INFORMANT
Mrs. Wm. D. Crump | | Address
(Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u>
4409 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4500 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1968, to March 20, 1968, that (I) (we) last
saw the deceased alive on March 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lawrence C. Post M.D. | | DEGREE | | ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED.
DIRECTOR | | <input type="checkbox"/> STAFF
PHYS. | | 22c. DATE SIGNED
3/20/68 | |
| 22d. PHYSICIAN'S
NAME (Type)
Dr. Lawrence C. Post | | 22e. ADDRESS
6805 York Road | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Entombment | | 23b. DATE
3/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Mausoleum | | 23d. LOCATION (City or Town)
Woodlawn, Balto. Co., Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. 4905 York Road
Balto., Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6370

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 5 Film G399
4/5/68 klc

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03708

| | | | | |
|--|-------------------------|--|--|---|
| 1. DECEASED-NAME
(Type or print)
Clara S. Jackson | | 2a. DATE OF DEATH
Month 3 Day 24 Year 1968 | | 2b. HOUR
M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
3/21/1877 1879 | | 6. AGE (In years last birthday)
89 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
983 Fairmount Ave | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Homemaker |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Towson |
| 14. FATHER'S NAME First Middle Last
Peter Uttenreither | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
NO | | 16b. SOCIAL SECURITY NO.
UNK. | | 17. INFORMANT Address
Madeline J. Gossman 983 Fairmount Ave |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
431.9 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c) 10 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
48 Hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
331X | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 2, 1947 to March 23, 1968 , that (I) <input checked="" type="checkbox"/> lost
saw the deceased alive on March 23, 1968 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the
causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death. | | | | |
| 22b. SIGNATURE
Charles F. O'Donnell | | 22c. DATE SIGNED
3/26/68 | | 22d. PHYSICIAN'S NAME (Type)
Charles F. O'Donnell |
| 22e. ADDRESS
7501 York Rd. | | 22f. ADDRESS | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/28/1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery |
| 23d. LOCATION (City or Town)
Baltimore | | 23e. COUNTY
Md. | | 23f. STATE
Md. |
| 24. FUNERAL DIRECTOR
Mitchell Wiedefeld Home | | 24a. ADDRESS
6500 York Rd. | | 24b. REC'D BY REGISTRAR
DATE MAR 28 1968 |
| 24c. REGISTRAR'S SIGNATURE
Charles Judge | | 24d. REGISTRAR'S SIGNATURE | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 03727 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 03709 | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|----------------------|--|--|--|--|-----------------------------------|--|--|--------------|--|--|---------------------|--|--|
| Item 23b Film G398 3/18/68 kk | | | | | | | | | | CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
JESSE | | | Middle
JAMES | | | Last | | | 2a. DATE OF DEATH
Month
MARCH | | | Day
11 | | | Year
1968 | | | 2b. HOUR
2:45 AM | | |
| 3. SEX
MALE | | | 4. RACE
NEGROID | | | 5. DATE OF BIRTH
4/25/94 | | | 6. AGE (In years
last birthday)
73 | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 HRS.
HOURS
MIN. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
VETERANS ADMIN. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
GUARD | | | 12b. KIND OF BUSINESS OR
INDUSTRY
FT. HOLABIRD | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
603 N. LONGWOOD STREET | | | | | | | | | | | |
| 14. FATHER'S NAME
First
THOMAS | | | Middle
JAMES | | | Last | | | 15. MOTHER'S MAIDEN NAME
First
MARTHA | | | Middle | | | Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
YES | | | 16b. SOCIAL SECURITY NO.
WW I
218-10-47-92 | | | 17. INFORMANT
CLINICAL RECORDS, VAH, FORT HOWARD, MD. | | | Address | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE STOMACH WITH METASTASIS</u>
<u>1519</u>
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. <u>151X</u>
DUE TO, OR AS A CONSEQUENCE OF
<u>TO THE LYMPH NODE AND LIVER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>ARTERIOSCLEROSIS OF CEREBRAL ARTERIES: ARTERIOLAR NEPHROSCLEROSIS</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? YES | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>FEB. 16</u> , 19 <u>68</u> , to <u>MARCH 11</u> , 19 <u>68</u> , that (X) (we) last
saw the deceased alive on <u>MARCH 11</u> , 19 <u>68</u> , and that in (X) (our) opinion death occurred on the date and hour and from the
causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Peter Juvan</u> | | | DEGREE
PETER V. JUVAN, M. D. | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/11/68 | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | 22e. ADDRESS
VA HOSPITAL, FORT HOWARD, MARYLAND | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | | 23b. DATE
3/15/1968 | | | 23c. NAME OF CEMETERY OR CREMATORY
Baltimore National Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
HAYES FUNERAL HOME | | | ADDRESS
638 N. Gilmore St.
Baltimore, Md. | | | 25a. REC'D BY REGISTRAR
DATE MAR 13 1968 | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Rodney Lee Jeske | | | 2a. DATE OF DEATH
Month March Day 10 Year 1968 | | | 2b. HOUR 8:20 P.M. | | | | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 10/18/68 | | 6. AGE (In years lost birthday) one YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 HOURS 0 MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Owings Mills Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rosewood State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 331 FONT HILL Ave. | | |
| 14. FATHER'S NAME First EUGENE R. Middle JESKE Last WATSON | | | 15. MOTHER'S MAIDEN NAME First LIVY Middle MAY Last WATSON | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. - | | 17. INFORMANT Address ROSEWOOD RECORDS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
431.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Infantile spasms
DUE TO, OR AS A CONSEQUENCE OF
(c) Encephalomalacia | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. 19 Month 2 Day 19 Year 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. A.A. Co. Md. | | City or Town A.A. Co. Md. | | County A.A. Co. Md. State A.A. Co. Md. | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 2/19 , 1968, to 3/10 , 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/10 , 1968, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Massoud Kaye | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3/10/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Massoud Kaye | | | | | | 22e. ADDRESS Rosewood State Hospital, Owings Mills, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 3/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL | | | 23d. LOCATION (City or Town) A.A. Co. Md. (County) A.A. Co. Md. (State) A.A. Co. Md. | | | |
| 24. FUNERAL DIRECTOR E S Mac Nabb ADDRESS Catonville Md. | | | | | | 25a. REC'D BY REGISTRAR DATE MAR 14 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03110

CENTRAL DEATH

03110



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03729

03711

| | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED-NAME
(Type or print) Nina L. Johnson | | | 2a. DATE OF DEATH
Month March Day 3 Year 68 | | | 2b. HOUR
5.30 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
July 17, 1892 | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS 75 DAYS 75 HOURS 75 MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
302 Rossiter Ave. | |
| 14. FATHER'S NAME First William Henry Middle B Last Boothe | | | 15. MOTHER'S MAIDEN NAME First Charlotte Middle Emily Last Watts | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO.
228-16-1475 | | 17. INFORMANT Address
Milton F. Boothe, Great Mills, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia and congestive heart failure
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4321 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 2/20 , 19 68 , to 3/31 , 19 68 , that (X) (we) last saw the deceased alive on 3/31 , 19 68 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Samuel O'Mansky | | 22c. DATE SIGNED
3/3/68 | | 22d. PHYSICIAN'S NAME (Type)
Samuel O'Mansky M.D. | | 22e. ADDRESS
7620 York Rd. Towson, Md. 21204 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. | | 25a. REC'D BY REGISTRAR
6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (1)
304 REV. 5/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03730

CERTIFICATE OF DEATH

03712

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First JAMES Middle ANDREW Last JONES | | | 2a. DATE OF DEATH
Month 3 Day 25 Year 68 | | 2b. HOUR
5:30pm |
| 3. SEX
MALE | 4. RACE
WHITE | 5. DATE OF BIRTH
3-18-67 | | 6. AGE (In years lost birthday)
1 YRS. | IF UNDER 1 YEAR
MONTHS
IF UNDER 24 HRS.
DAYS
HOURS
MIN. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
BALTIMORE COUNTY Md. | | |
| 10. CITY OR TOWN OF DEATH
OWINGS MILLS | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ROSEWOOD STATE HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
DEPENDENT | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | 13b. COUNTY
WASHINGTON | 13c. CITY OR TOWN
FAIRPLAY | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
ROUTE # I | |
| 14. FATHER'S NAME First WILLIAM Middle JENNINGS Last JONES | | 15. MOTHER'S MAIDEN NAME First CONNIE Middle JEAN Last HURD | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
----- | | 17. INFORMANT Address
ROSEWOOD'S RECORDS OWINGS MILLS, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration acidosis
561X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5770
(b) Gastroenteritis, acute
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1) Cerebral defect, congenital; Mental and physical Arthrogryposis, congenital. retardation, severe. | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/29 , 19 68 , to 3/25 , 19 68 , that (I) (we) last saw the deceased alive on 3/25 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
D. Crosby Greene M.D. | DEGREE
M.D. | ATTENDING PHYS. <input type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
3/26/68 |
| 22d. PHYSICIAN'S NAME (Type) D. Crosby Greene, M.D. | | 22e. ADDRESS
Rosewood State Hosp., Owings Mills, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE
3- 28- 68 | 23c. NAME OF CEMETERY OR CREMATORY
Manor Cemetery | 23d. LOCATION (City or Town) (County) (State)
Tilghmanton Wash. Co., Md. | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | ADDRESS | 25a. REC'D BY REGISTRAR
APR 1 - 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

03730

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Department of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

Division of Health

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|------------------------------------|--|------|---|--|--|--|
| 03731 CERTIFICATE OF DEATH 03713 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | |
| JULIA | | | M. | | J | | ORIO | | March 2 1968 | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | |
| female | | | caucasian | | | Aug. 9, 1882 | | | 85 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Italy | | | USA | | | | | | Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| suburban Balto. | | | 6711 Collinsdale Ave. | | | housewife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Md. | | | Balto. | | | Balto. | | | 6711 Collinsdale Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| John | | | Rose | | | Palma | | | ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| | | | 220-54-2938 | | | Mr. Joseph J. Jorio | | | (Same) | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> | | | | | | | | | | 6 hours | |
| 4100 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) <u>Hypertensive arteriosclerotic cardiovascular disease</u> | | | | | | | | | | 10 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 8, 1959, to March 1, 1968, that (I) (we) last saw the deceased alive on March 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Leo Schlenger</u> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | |
| 22c. DATE SIGNED 3/2/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Leo Schlenger | | | | | | | | | | | |
| 22e. ADDRESS 6100 Loch Raven Blvd, Balto. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 3/5/68. | | Holy Redeemer Cemetery | | | Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Leonard J. Ruck, Inc.-Balto, Md.-14 | | | | | | | | DATE MAR 4 1968 | | Charles Judge | |

1951

REVENUE OF STATE

1951

STATE OF NEW YORK

IN SENATE

January 1, 1951

REPORT OF THE COMMISSIONER OF THE DEPARTMENT OF TAXATION AND FINANCE

FOR THE YEAR ENDING DECEMBER 31, 1950

ALBANY

1951-1952

THE COMMISSIONER OF THE DEPARTMENT OF TAXATION AND FINANCE
ALBANY, NEW YORK
1951-1952

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03732

03714

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
June Clara JOSEPH | | | 2a. DATE OF DEATH
Month 2 Day 13 Year 68 | | | 2b. HOUR
10:45p | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
1/21/59 | | 6. AGE (In years last birthday)
9 YRS. | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Dependent | | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Worcester | | 13c. CITY OR TOWN
Berlin | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
Box 36 - 204 Broad Street | | |
| 14. FATHER'S NAME First Middle Last
Bobby Lee Joseph | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Clara Louise Perdue | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) -- | | | 16b. SOCIAL SECURITY NO.
none | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Necrotizing bronchial pneumonia
485x
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 491x
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Institutionalization Metachromatic Cerebral Leukodystrophy | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (s) (this hospital) attended the deceased from 7/23 , 19 64 , to 3/13 , 19 68 , that (s) (we) last saw the deceased alive on 3/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Richard A. Jones DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
3/14/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Richard A. Jones, M.D. | | | | | | 22e. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
NEW HOPE | | 23d. LOCATION (City or Town) (County) (State)
KILLARDS VIC MD | | | | | |
| 24. FUNERAL DIRECTOR
Hubbard Funeral Home | | | | | | 25a. REC'D BY REGISTRAR
21224 | | 25b. REGISTRAR'S SIGNATURE
Mar 18 1968 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03733

03715

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) MARY E. KALB | | First Middle Last | | 2a. DATE OF DEATH
Month Day Year MARCH 7 1968 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
3-7-1897 | | 6. AGE (In years last birthday)
71 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | |
| 10. CITY OR TOWN OF DEATH
BALTIMORE | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3516 MAYFAIR RD | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
At Home | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
BALTO | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
5008 Reisterstown Rd | | 14. FATHER'S NAME
First Middle Last
CLARENCE MOORE | | 15. MOTHER'S MAIDEN NAME
First Middle Last
AMOS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
— | | 17. INFORMANT
LOUIS C. SHARRER - 803 GEIST ROCK | | Address
GLEN BURNE, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary occlusion
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 week
20 yr | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 Diabetes | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 1951 to March 7, 1968 , that (I) (we) lost saw the deceased alive on March 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Joseph B Gross | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type)
Joseph B Gross | | 22e. ADDRESS
6900 Paulding Rd Baltimore | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-11-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
BALTO, MD BALTO | |
| 24. FUNERAL DIRECTOR
ETSWORTH ARMAGOST | | ADDRESS
4600 Liberty Hgts Ave | | 25a. READY REGISTRAR
MAR 11 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| 03734 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03716 | | | |
|---|--|--|--|--|--|--|--|-----------------|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| LENA — KAMMER | | | | Month 11 Day 68 Year 11:20 AM | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | White | | 11-17-1877 | | 90 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| GERMANY | | U.S.A. | | | | Baltimore | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Baltimore | | G.B.M.C. | | Housewife | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | | | 3404 Hamilton Ave. | | | | | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| Karl — Neumann | | Mina — Neumann | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | |
| No | | | | Mrs Anna K Garber | | Same | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Acute Congestive failure | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic cardiovascular disease | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/11, 1968, to 3/11, 1968, that (I) (we) last saw the deceased alive on 3/11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Derek A Bruce | | 22c. DATE SIGNED 3/11/68 | | 22d. PHYSICIAN'S NAME (Type) DEREK H. BRUCE | | 22e. ADDRESS G.B.M.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 3/15/68 | | Lorraine Park | | Baltimore, Maryland | | | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Leonard J Ruck Inc., Baltimore, Maryland | | DATE MAR 12 1968 | | J. J. Judge | | | | | | | |

02730

DATE OF BIRTH

DATE

RESIDENCE

ADDRESS

DATE OF BIRTH

DATE

RESIDENCE

DATE OF BIRTH

DATE

DATE

DATE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03735

03717

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|---|--|---|---|--|
| 1. DECEASED-NAME
(Type or print) | | First
Anna | | Middle
Madjewski | | Last
Katovich | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| | | | | | | | | Month
3 | | | Day
5 | | |
| | | | | | | | | Year
68 | | | 11 ¹⁰ M | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
July 15, 1904 | | | 6. AGE (In years last birthday)
63 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS.
HOURS
MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Russia | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Balto. | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2104 Westfield Avenue | |
| 14. FATHER'S NAME
? ? | | | First
Middle
Last
Madjewski | | | 15. MOTHER'S MAIDEN NAME
First
Middle
Last
Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
123-01-0581 | | | 17. INFORMANT
Address
Records: SPRING GROVE STATE HOSPITAL | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>myocardial infarction</u>
4109
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 day | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
430.1 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY
(AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.O. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Aug. 13</u> , 19 <u>67</u> , to <u>March 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/5</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Sherwood Wilson M.D.</u> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/5/68</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Sherwood Wilson, M.D. | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/9/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Fern Knoll Burial Park | | | 23d. LOCATION (City or Town) (County) (State)
Dallas, Pa. | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | 25a. REC'D BY REGISTRAR
DATE <u>MAR 7 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Young</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

STATE OF TEXAS

11111

County of _____

Know all men by these presents, that _____

of the County of _____ State of Texas

do hereby certify that _____

is the true and correct owner of _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

and that the same is duly recorded in _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03736

CERTIFICATE OF DEATH

03718

| | | | | | | | |
|---|--|--|---|--|--|--|--|
| 1. DECEASED-NAME (Type or print) RACHEL First Middle Last | | | 2a. DATE OF DEATH MARCH 6 1968 Month Day Year | | | 2b. HOUR 8 25 AM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH SEPT. 4, 1899 | | 6. AGE (In years lost birthday) 68 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore | |
| 10. CITY OR TOWN OF DEATH RANDALLSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BALTO. COUNTY GEN. HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY BALTIMORE | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 4010 OAKFORD AVE. | | | | | | | |
| 14. FATHER'S NAME First Middle Last LEOPOLD BERNSTEIN | | | 15. MOTHER'S MAIDEN NAME First Middle Last ELLA MARGOLIS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) HEMOLYTIC ANEMIA
DUE TO, OR AS A CONSEQUENCE OF
(b) MYELOGENOUS LEUKEMIA
DUE TO, OR AS A CONSEQUENCE OF
(c) POLYCYTHEMIA VERA | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 WEEKS
3 MOS.
5 YRS. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 5, 1968 , to MARCH 6, 1968 , that (I) (we) lost saw the deceased alive on MARCH 6 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Marvin Goldstein | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 3/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN | | | | 22e. ADDRESS 6001 PARK HEIGHTS AVE. BALTO. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Mar. 7, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rosedale | | 23d. LOCATION (City or Town) (County) (State) Baltimore County, Md. | |
| 24. FUNERAL DIRECTOR Sylvan S. Lewis & Son | | | | ADDRESS Garrison, Md. | | 25a. REC'D BY REGISTRAR MAR 8 1968 DATE | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

03780

RECEIVED

03780

1000

1000

1000

1000

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1000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | | | |
|---|--|------------------------------|--|--|--|------------------------------------|--|---|--|--|--|--|--|----------------------------|--|--|--|------------------|--|
| Margaret Van Houton Kavanaugh | | | | | | | | | | March 9, 1968 | | 1:05 PM | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | |
| F | | W | | Aug. 14, 1902 | | | | 65 YRS. | | MONTHS | | DAYS | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | | | | |
| Penna. | | U. S. A. | | | | Baltimore Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Towson | | | | St. Joseph's | | | | Homemaker | | | | Own Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | |
| Md. | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 629 E. 29th St. | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| George VanHouten | | | | Kathryn Tsch | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | | | | |
| No | | | | 180-03-3212-D | | Mrs. Margaret Laing | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Generalized carcinoma of the | | | | | | | | | | | | 2 yr. | | | | | | | |
| 174X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | 4 yr. | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) Ca. of breast | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 170X | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/30, 1953 to 3/9, 1968, that (I) (we) last saw the deceased alive on 2/29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Dr. Norman R. Freeman, Jr. | | | | | | | | | | | | | | | | 3/9/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | 22e. ADDRESS | | | | | | | |
| Dr. Norman R. Freeman, Jr. | | | | | | | | | | | | 11 W. 29th St. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | 3/12/68 | | Dulaney Valley Mem. Grds. | | | | Timonium Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212 | | | | | | | | | | | | MAR 13 1968 | | | | | | | |

03119

DEPARTMENT OF HEALTH

03119

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|---|-------|--|---|---|---|
| 03738 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 03720 | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | |
| John | | | Harry | Kelly | 3 1 1968 | | 2b. HOUR
6 A M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | |
| Male | | Cau. | | 2- 22- 1897 | | 71 YRS. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Baltimore | | U.S.A. | | Baltimore | | Md. | |
| 1d. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Rosedale | | 8211 Philadelphia | | Machinist | | Crown Cork Co | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md | | Baltimore | | Rosedale | | 8211 Philadelphia Road 37 | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | |
| John | | | H. | Kelly | Annie | | Kloppmyer |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| No | | | | 213-01-0407A | | Mrs Nellie M. Einschutz 8337 Philadelphia R | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | Sudden |
| 2509 Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) Arteriosclerotic Cardiac Vascular | | | | | | | 5 yrs |
| (c) Diabetes Mellitus | | | | | | | 10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 260x | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | Jan 1, 1966, to Feb 29, 1968, that (I) (we) lost
saw the deceased alive on Feb 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING
PHYS. | | MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S
NAME (Type) | | G.M. BAUM | | 9214 NEP Baltimore | | 22e. ADDRESS | |
| | | | | | | 21237 | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | 3-4-1968 | | Oak Lawn Cemetery | | Baltimore Co. Md. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | |
| Lassahn Funeral Home | | | | 7401 Belair Rd 21236 | | DATE MAR 4 1968 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | | | Charles Jones | |

03130

THE OFFICE OF DEATH

03130

THIS DOCUMENT IS A REPRODUCTION OF A DOCUMENT FROM THE NATIONAL ARCHIVES AT COLLEGE PARK, MARYLAND. IT IS NOT A COPY OF THE ORIGINAL DOCUMENT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 23b Film G38 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

4/5/68 kkk

03733

CERTIFICATE OF DEATH

03721

| | | | | | | | | | | | |
|---|--|---|--|---|-------------------------|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Chester | | First CESLAW | | Middle | Last Kendzierski | | 2a. DATE OF DEATH
Month MARCH Day 30 Year 1968 | | | 2b. HOUR
M | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
July 3, 1905 | | 6. AGE (in years
last birthday) 62 | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) MD. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | | |
| 10. CITY OR TOWN OF DEATH
UPPER FALLS | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
UPPER FALLS | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
WEISKETTLE | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE MD | | 13b. COUNTY
BALTO. | | 13c. CITY OR TOWN
UPPER FALLS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
UPPER FALLS | | | |
| 14. FATHER'S NAME First ANTHONY Middle KENDZIERSKI Last CATHERINE | | 15. MOTHER'S MAIDEN NAME First CROJNOWSKA Middle CROJNOWSKA Last CROJNOWSKA | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
265-03-2283 | | 17. INFORMANT
Address ANITA KENDZIERSKI Upper Falls Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Lymphocytic Leukemia
2041
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
1 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
2040 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1955 to March, 1968 , that (I) (we) last
saw the deceased alive on March 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
William A. Tyson M.D. | | 22c. DATE SIGNED
3-30-68 | | 22d. PHYSICIAN'S
NAME (Type) William A. Tyson | | | | | | | |
| 22e. ADDRESS
Hingsville, Md. | | 22f. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVED (Specify) | | 23b. DATE
4-2/68 | | 23c. NAME OF CEMETERY OR CREMATORY
HOLY ROSARY CEM. | | 23d. LOCATION (City or Town) (County) (State)
BALTO MARYLAND | | | | | |
| 24. FUNERAL DIRECTOR
JOHN M. WEBER & SONS INC | | 24a. ADDRESS
401 S. CHESTER ST | | 25a. RECEIVED BY REGISTRAR
APR 1 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

13746

RECEIVED IN DEPT.

68523

W

1

1948-03-20

1948-03-20

1948-03-20

1948-03-20

1948-03-20

1948-03-20

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

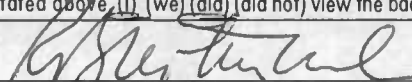

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03740

03722

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|--|------------------------------------|--|---|--|------|--|
| 1. DECEASED-NAME
(Type or print) | | First
JOHN | | Middle
HAROLD | | Last
KILMORE | | 2a. DATE OF DEATH
3 Month 12 Day 68 Year | | | | 2b. HOUR
10A M | | | |
| 3. SEX
Male | | 4. RACE
Cau. | | 5. DATE OF BIRTH
12/24/1907 | | | | 6. AGE (In years
lost birthday)
60 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign
country)
Balto.Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore, Maryland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Gr. Balto. Md. Center | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Sanitarian Agent | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
How.Co. | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Balto. | | 13c. CITY OR TOWN
Balto. | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Health Dept.
1408 Sedgwick Rd. | | | | | | | |
| 14. FATHER'S NAME | | First
Michael | | Middle
Hart | | Last
Kilmore | | 15. MOTHER'S MAIDEN NAME | | First
Lillie | | Middle
B. Miller | | Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
Yes | | (If yes give war or dates of service)
WWII | | 16b. SOCIAL SECURITY NO.
214-46-8394 | | 17. INFORMANT
Mrs. Pauline E. Kilmore | | Address
(Same) | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4519 Massive pulmonary embolism
DUE TO, OR AS A CONSEQUENCE OF
(b) Phlebothrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
466X | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
3/4/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Carcinoma of left colon | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? Yes | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | | State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/1, 19 68, to 3/12/ 19 68, that (I) (we) last
saw the deceased alive on 3/12/ 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
 | | DEGREE | | ATTENDING
PHYS. | | <input type="checkbox"/> MED.
DIRECTOR | | <input type="checkbox"/> STAFF
PHYS. | | 22c. DATE SIGNED
March 12, 1968 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | RUDIGER BREITENECKER, M.D. | | 22e. ADDRESS
Greater Baltimore Medical Center | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE
3/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Mem. Grds. | | 23d. LOCATION (City or Town) | | (County) | | (State)
Md. | | | | | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons | | ADDRESS
4905 York Rd.
Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1968 | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | | |

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(100)

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FOR STATE HEALTH DEPT.

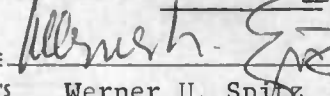

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03741

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03723

| | | | | | | | | | | | |
|--|---------|--|--|--|--------------------------------|--|--------------------------------|---|---------------------------------|---|-----------|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 20. DATE KNOWN OF DEATH ESTIMATED | | 2b. HOUR | |
| Harry | | L. | | | | KING | | Month Day Year
3/20 1968 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR |
| male | white | 2/13/10 | | 58 YRS. | | | | | Month Day Year
March 23 1968 | | 4:30 P. M |
| 70. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| BALTO. | | US | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| BALTO. | | 1313 OLD EASTERN RD | | | | CLERK | | BALD CITY | | | |
| 130. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Baltimore | | MD | | | | 1113 Old Eastern Ave. Apt D | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| Wm. H. | | | | | | King | | Helen | | Thompson | |
| 160. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| | | | | 217-07-4473 | | MURLE ELLIOTT | | 3705 MANCHESTER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)
4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | Werner U. Spitz, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 3/26/68 | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 3/28/68 | | Oak Lawn Cem | | Baltimore | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 250. REGISTERED BY REGISTRAR | | 250b. REGISTRAR'S SIGNATURE | |
| J. Klemm | | | | 6007 Hwy Rd | | | | MAR 29 1968 | |  | |

03750

RECEIVED EXAMINATION OF WORTH

03750

RECEIVED EXAMINATION OF WORTH

1

RECEIVED EXAMINATION OF WORTH

78-1000 039 1237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03742

03724

| | | | | | |
|--|------------------|--|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last
Leah A. Kirby | | | 2a. DATE OF DEATH Month 3 Day 29 Year 68 | | 2b. HOUR
9.45 |
| 3. SEX
Female | 4. RACE
White | | 5. DATE OF BIRTH
Feb. 18, 1882 | | 6. AGE (In years last birthday) 86 YRS. |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
STELLA MARIS HOSPICE NW. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Baltimore | 13c. CITY OR TOWN Baltimore | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
4301 Roland Ave. |
| 14. FATHER'S NAME First Middle Last
Murtha Walsh | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Julia Montague | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)
no | | 16b. SOCIAL SECURITY NO.
217-48-5894 | | 17. INFORMANT Address
Stella maris records | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>lobar pneumonia</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CVA</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 week |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-13-65, 19, to 3-29, 1968, that (I) (we) lost saw the deceased alive on 3-26-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Robert J. Mahon | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-29-68 | |
| 22d. PHYSICIAN'S NAME (Type)
ROBERT J. MAHON M.D. | | 22e. ADDRESS
204 E. Joppa | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify)
Burial | | 23b. DATE
4-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peters | |
| 23d. LOCATION (City or Town) (County) (State)
Harpers Ferry W. Va. | | | | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson, | | ADDRESS
1050 York Road
Towson, Maryland 2120 | | 25a. RECEIVED BY REGISTRAR
APR 1 - 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
James J. Judge | |

43760

WINDY

43760



Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-54

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 03725 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print)
MARGARET | | First
M. | | Middle
KIRK | | Last
KIRK | | 2a. DATE OF DEATH
March 20 , Day 20 , Year 1968 | | 2b. HOUR
11:30P | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
August 31, 1915 | | 6. AGE (In years lost birthday)
52 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
3119 Glendale Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
3119 Glendale Avenue | | | |
| 14. FATHER'S NAME First Middle Last
Frederick Moran | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
ROSE JEFFRA | | | | Address
(Same) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO.
216-03-385 | | 17. INFORMANT
Mr. Arthur F. Kirk | | | | Address
(Same) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Uremia
180X DUE TO, OR AS A CONSEQUENCE OF Carcinoma of Cervix
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 18 mos.
(b) _____
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY:
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from April 19, 1967 to Mar 20, 1968 , that (I) (we) last saw the deceased alive on March 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
George J. Richards, MD | | DEGREE
MD | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS.
<input type="checkbox"/> | | 22c. DATE SIGNED
3/21/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | George J. Richards Jr. | | 22e. ADDRESS
Greater Baltimore Med. Center | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/25/68 | | 23c. NAME OF CEMETERY OR CREMATORY
PARKWOOD CEM. | | 23d. LOCATION (City or Town) (County) (State)
PARKVILLE BALD. MD | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
MAR 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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03723

MARINE

NAME

March

10

1961

11:30

22

August 11, 1961

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White

Leftovers

100

USA

Marine

Baltimore

3119 Chesapeake Ave.

3119 Chesapeake Ave.

3119 Chesapeake Avenue

Baltimore

Baltimore

Marine

Marine

(phone)

Mr. Arthur J. [unclear]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Mamie Marie Klippert | | | 2a. DATE OF DEATH
Month Day Year
THUR March 7, 1968 | | 2b. HOUR
p.m.
2:30 |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
Jan. 12, 1886 | | 6. AGE (In years last birthday)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
Md. | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
SPRING GROVE STATE HOSP. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
housewife | 12b. KIND OF BUSINESS OR INDUSTRY
AT HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | 13b. COUNTY
Balto. | 13c. CITY OR TOWN
Balto. | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER (East 4th Ave.)
417 East Lynn Avenue 21223 | |
| 14. FATHER'S NAME First Middle Last
Harry Lindeman | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Knowlman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
212-26-0404-J1 | | 17. INFORMANT Address
Records: SPRING GROVE STATE HOSPITAL | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
4129 DUE TO, OR AS A CONSEQUENCE OF
(b) Generalized arteriosclerosis, severe
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 Diabetes mellitus | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work of work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 1, 1962 , to March 7, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on March 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Stella Wachslar | | DEGREE | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED
3-7-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Stella Wachslar, M.D. | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Baltimore, Maryland 21228 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE
MARCH 11, 1968 | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN Cem. | | 23d. LOCATION (City or Town) (County) (State)
WOODLAWN, BALTO Co, Md. | |
| 24. FUNERAL DIRECTOR
CURTIS E. EVANS | | ADDRESS
1400 S. CHARLES ST 21230 | | 25a. REC'D BY REGISTRAR
DATE
MAR 8 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

03750

03750

CHARTER OF 1934

CHARTER OF 1934

CHARTER OF 1934

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (M)
30M REV. 1-68

MEDICAL CERTIFICATION

| 1. DECEASED-NAME
(Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH | | | | 2b. HOUR | | | | | |
|--|--|------------------------------|--|---|--------|---|------------------------------------|--|-----------------|---|------------------|---|-------|---|---------|--|
| | | | | Month | Day | Year | | | | | | | | | | |
| 03745 | | | | GEORGE | | W. | KNIGHT | | 3 | | 6 | | 1968 | | 6:00 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| M | | W | | 1-11-1893 | | | 75 | | MONTHS | | DAYS | | HOURS | | MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | | |
| U.S.A. Md. | | U.S.A. | | | | Baltimore County. Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Batonville, MO | | | | Spring Grove State Hosp. | | | | Farmer | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | |
| MO | | | | Prince George | | Accokeek | | | | Route #1 Box 156 | | | | | | |
| 14. FATHER'S NAME | | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | | First | Middle | Last | | | |
| | | | | Unknown | | | | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | |
| | | | | 217-18-1948 | | Hospital Records Spring Grove State Hosp. | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive heart infarct</u>
<u>4109</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. <u>4-20-1</u>
(b) <u>Cardiac arrest.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>Generalized arteriosclerosis</u> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> , 19 <u>67</u> , to <u>3-6</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last
saw the deceased alive on <u>3-6</u> , 19 <u>68</u> , and that in <u>MD</u> (our) apinian death occurred on the date and hour and from the
causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Stella Wachslar</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | | | | | | 22c. DATE SIGNED <u>3-7-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M.D.</u> | | | | | | | | | | | | | | 22e. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>
<u>Baltimore, Maryland 21228</u> | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| <u>Burial</u> | | | | <u>March 9, 1968</u> | | <u>Ft Lincoln Cemetery</u> | | | | <u>Colmar Manor Pro Geo Md.</u> | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>F. Gasch's Sons</u> | | | | | | <u>Hyattsville, Md.</u> | | | | DATE <u>MAR 11 1968</u> | | <u>Charles J. [Signature]</u> | | | | |

03184

STATE OF TEXAS

03184

RECEIVED BY THE SECRETARY OF THE STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03746

03728

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) Marie Annio Knighton | | | 2a. DATE OF DEATH
Month 3 Day 1 Year 68 | | | 2b. HOUR
M | | | |
| 3. SEX
F | | 4. RACE
Cau | | 5. DATE OF BIRTH
12-2-13 | | 6. AGE (In years last birthday)
54 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Baltimore Med Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md. | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1408 Hollins Street | |
| 14. FATHER'S NAME First Middle Last
Charles Frank Collier | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Bertha Lee Poppleton Dean | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | |
| 16b. SOCIAL SECURITY NO.
219-20-5275 | | | 17. INFORMANT
Larry Knighton Balto., Md. 21201 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Cervix
180X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
171X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
[Signature] | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3-1-68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
R. Q. Barry MD. | | 22e. ADDRESS
Baltimore | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY
Standardsville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Standard, Va. | | | |
| 24. FUNERAL DIRECTOR
Witzke F. D., Balto., Md. 21229 | | | | 25a. REC'D BY REGISTRAR
DATE MAR 4 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

08780

RECORD OF DEEDS

08780

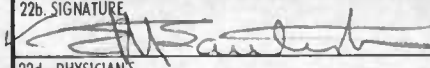
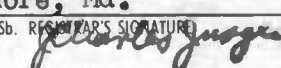
RECORD OF DEEDS

RECORD OF DEEDS

RECORD OF DEEDS

10-2-6
1M
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03747
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
03729

| | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First
JOSEPH | | | Middle
R. | | | Last
KRESSLEIN, Jr. | | | 2a. DATE OF DEATH
MARCH Month 27, Day 1968 | | | 2b. HOUR
3:00 M | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
SEPTEMBER 23, 1932 | | | 6. AGE (In years last birthday)
35 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE, Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Prof. Rep. | | | 12b. KIND OF BUSINESS OR INDUSTRY
SHARP & DOHME | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
2510 PARKTRAIL RD. #21234 | | | | | |
| 14. FATHER'S NAME
First Middle Last
Joseph R. Kresslein | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Margaret F. Shunk | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
Yes | | | (If yes give war or dates of service)
Korean | | | 16b. SOCIAL SECURITY NO.
213-30-1242 | | | 17. INFORMANT
Mrs. Nancy E. Kresslein | | | Address
(Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) OBSTRUCTIVE JAUNDICE
1729
DUE TO, OR AS A CONSEQUENCE OF
METASTATIC MELANOMA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1909 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 10 1968, to MARCH 27, 1968, that (I) (we) last saw the deceased alive on MARCH 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
 M.D. | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
MARCH 27, 1968 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
EDILBERTO BAUTISTA, M.D. | | | 22e. ADDRESS
7620 YORK ROAD TOWSON, MD. #21204 | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
3/30/68. | | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE MAR 27 1968 | | | 25b. REGISTRAR'S SIGNATURE
 | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div style="display: flex; justify-content: space-between;"> 03748 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03730 </div> <div style="text-align: center;"> CERTIFICATE OF DEATH </div> | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|---|--|--|---------------------------|--|
| 1. DECEASED-NAME
(Type or print) | | | First
ALLAN | | | Middle
T. | | | Last
LAKIN | | | 2a. DATE OF DEATH
Month 3 Day 4 Year 68 | | | 2b. HOUR
2:40PM | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
2/20/97 | | | 6. AGE (In years last birthday)
71 YRS. | | | IF UNDER 1 YEAR
MONTHS 71 DAYS 71 | | IF UNDER 24 HRS.
HOURS 71 MIN. 71 | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE COUNTY, Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CLERK | | | 12b. KIND OF BUSINESS OR INDUSTRY
STANDARD OIL | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
2819 ONTARIO AVENUE | | | | |
| 14. FATHER'S NAME
First WILLIAM Middle D. Last LAKIN | | | 15. MOTHER'S MAIDEN NAME
First AMANDA Middle J. Last JOHNSON | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, YES (If yes give war or dates of service)
WW I | | | 16b. SOCIAL SECURITY NO.
215 18 86 82 | | | 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | Address | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) EMPHYEMA OF GALL BLADDER WITH PERICHOLECISTIC ABSCESS
5749
DUE TO, OR AS A CONSEQUENCE OF
(b) CHOLELITHIASIS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5848
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
PEPTIC ULCER OF HIATUS HERNIA WITH HEMORRHAGE | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 2/27/68 , 19 68 , to 3/4/68 , 19 68 , that (1) (we) last saw the deceased alive on 3/4/68 , 19 68 , and that in (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
John D. Talbert, M.D. | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED
3/5/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
JOHN D. TALBERT, M. D. | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3/7/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
DULANEY VALLEY MEMORIAL GARDENS | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | | | | | |
| 24. FUNERAL DIRECTOR
ROBERT C. ALTENBURG FUNERAL HOME, INC. | | | ADDRESS
6009 HARBOR ROAD, BALTIMORE, MD. 21211 | | | 25a. REC'D BY
1988 | | | 25b. FUNERAL DIRECTOR'S SIGNATURE
Charles Judge | | | | | | | |

MARCH 8, 1968

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0520

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 08-06-98 BY SP-6 BJS/BJS

[illegible]

REFERENCES

1. STATE OF NEW YORK

281

Handwritten notes in Urdu script, likely bleed-through from the reverse side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 7-68

03749
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03731

| | | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) Janet | | First Janet | | Middle Ann | | Last La Martina | | 2a. DATE OF DEATH
Month 3 Day 25 Year 68 | | 2b. HOUR
6 PM | | |
| 3. SEX
Female | | 4. RACE
cau. | | 5. DATE OF BIRTH
10-25-31 | | 6. AGE (In years last birthday)
36 YRS. | | IF UNDER 1 YEAR
MONTHS 36 DAYS 36 | | IF UNDER 24 HRS.
HOURS 36 MIN. 36 | | |
| 7a. BIRTHPLACE (State or foreign country)
md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Greater Baltimore Medical Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
ins. Rater | | 12b. KIND OF BUSINESS OR INDUSTRY
ins. R. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
md | | 13b. COUNTY
Balto | | 13c. CITY OR TOWN
city | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1340 Silverthorn, 21212 | | | | |
| 14. FATHER'S NAME
First Byron Middle I Last Freed. | | 15. MOTHER'S MAIDEN NAME
First Ella Middle (GREGOR) Last REED | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
218263048 | | 17. INFORMANT
Michael La Martina (son) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) extensive metastasis
1830
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) 1° ca of the ovary
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1750 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 6, 1968 , to March 25, 1968 , that (I) (we) last saw the deceased alive on March 25, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Lilia C. Baldonado DEGREE <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | 22c. DATE SIGNED
3-25-68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO | | | | | | | | 22e. ADDRESS
ABAM C | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
3/29/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer | | 23d. LOCATION (City or Town) (County) (State)
Bellevue Rd. Balt Md | | | | | | |
| 24. FUNERAL DIRECTOR
Leah Cook 7200 Harford Road | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 28 1968 | | 25b. REGISTRAR'S SIGNATURE
John Judge | | | | |

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "January" and "Baltimore" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

81-06043

| <div style="display: flex; justify-content: space-between;"> <div> <p>03750 Item #13</p> </div> <div> <p>MD. DEPT. OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>03732</p> </div> </div> | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Baby Boy | | | First Middle Last LANKFORD | | | 2a. DATE OF DEATH Month March Day 27 Year 1968 | | | 2b. HOUR 2:31 AM | | | |
| 3. SEX Male | | | 4. RACE Cau. | | | 5. DATE OF BIRTH 3-26-68 | | | 6. AGE (In years last birthday) YRS. | | IF UNDER 1 YEAR MONTHS 1 DAYS + | |
| 7a. BIRTHPLACE (State or foreign country) md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore Co. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) g. B. M. C. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | | 13b. COUNTY Balto. | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 519 Wickham Road | | | |
| 14. FATHER'S NAME First Middle Last Thomas Talmadge Lankford III | | | 15. MOTHER'S MAIDEN NAME First Middle Last Carol Lynn Jackson | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NEW BORN | | | 16b. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT chart - Infant Birth Information | | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7762 | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RESPIRATORY DISTRESS SYNDROME | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURITY | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7735 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 3/26/68 , 19 68 , to 3/27 , 19 68 , that (a) (we) last saw the deceased alive on 3/27 , 19 68 and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Kieffer Mitchell | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 3/27/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) KIEFFER J. MITCHELL | | | 22e. ADDRESS GREATER BALTO. MED. CENTER | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | | 23b. DATE 3/29/68 | | | 23c. NAME OF CEMETERY OR CREMATORY G.B.M.C. | | | 23d. LOCATION (City or Town) (County) (State) Towson Balto. Md. | | | |
| 24. FUNERAL DIRECTOR John E. Adams, Md.D. | | | ADDRESS G.B.M.C. | | | 25a. REC'D BY REGISTRAR DATE APR 2 - 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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VR A15
OM REV. 1/68

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|---|--|--|--|--|--|--|--|-----------------------------|--|
| 1. DECEASED NAME
(Type or print) | | First Middle Last | | 2a. DATE OF DEATH | | Month Day Year | | 2b. HOUR P M | |
| Joseph NMI Lansberg | | | | 3 13 68 | | | | 10:30 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | 08/22/04 | | 82 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Latvia | | U.S.A. | | | | Baltimore County | | Md | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Randallstown | | Balto. Co. Gen. Hosp. | | CABINET RETIKER MAKER FURNITURE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Md. | | Balto. | | | | 3507 Gardenview Road | | | |
| 14. FATHER'S NAME First Middle Last | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Simon Lansberg | | Catherine Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | 215-10-04644 | | MRS. GERTRUDE HANKIN | | 3507 GARDENVIEW RD. #21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | Acute Myocardial Infarction | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4109 | | DUE TO, OR AS A CONSEQUENCE OF | | 2° Gen. ASCVD with Atrial | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | DUE TO, OR AS A CONSEQUENCE OF | | Fibrillation & Congestive Cardiac Failure | | | |
| (c) | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-13, 1968, to 3-13, 1968, that (I) (we) last saw the deceased alive on 3-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| Diadema Simon-Tayag, M.D. | | 3-13-68 | | BALTIMORE COUNTY GENERAL HOSPITAL | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 3-15-68 | | RODDE ZEDEK | | BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN RD | | DATE | | MAR 18 1968 | | Charles Judge | | | |

16760

Notes

2000.04.28

8. 7. 2017

• 1990 •

Abstract

1. *Staphylococcus aureus*

10

2

Table 2

1932.

Figure 1

• • • • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1314)
30M REV. 1/68

| <div> <div>Item 1 Film G399</div> <div>4/2/68 klk</div> <div>03752</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03734</div> </div> | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--------------------------------|
| 1. DECEASED-NAME
(Type or print)
Robert Edward LAUBACH | | | | | | 2a. DATE OF DEATH
Month 31 , Day 1968 | | | 2b. HOUR
4:45 M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MARCH 28, 1968 | | | 6. AGE (In years lost birthday)
YRS. MONTHS 3 DAYS | | IF UNDER 1 YEAR
MONTHS 3 HOURS | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
INFANT | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | | 13c. CITY OR TOWN
TOWSON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7423 KENLEA AVE. #21236 | |
| 14. FATHER'S NAME First Middle Last
RICHARD E. LAUBACH | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
LOUISE E. STACHOWIAK | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mr Richard E. Laubach 7423 Kenlea Avenue | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity
7761
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hyaline membrane disease.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
7735 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 28, 1968 , to MARCH 31, 1968 , that (I) (we) lost saw the deceased alive on MARCH 31, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ludilina M. Oteyza | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 31, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ludilina Oteyza, M.D. | | | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith Cem. | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co. Md. | | | | | |
| 24. FUNERAL DIRECTOR
Lassell Funeral Home 7401 Belair Road | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 2 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

81-06044

1878

RECEIVED

1878



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with, Form PM-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03753

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03735

| | | | | | | | | | | | | |
|--|---------------------|--|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or Print) KORNELIUS | | First | | Middle | | Last | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED 2 MAR 17 68 | | 2b. HOUR
12:13 PM | | |
| 3. SEX
M | 4. RACE
W | 5. DATE OF BIRTH
5 12 31 | | 6. AGE (In years
last birthday)
36 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year
MAR 17 1968 | | |
| 7a. BIRTHPLACE (State or foreign
country) Holland | | 7b. CITIZEN OF WHAT COUNTRY?
Holland | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE | | | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
ST. JOSEPH HOSP. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Professor | | | 12b. KIND OF BUSINESS OR
INDUSTRY
Teacher | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN
Cockeysville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
110 Warren Rd. | | | | |
| 14. FATHER'S NAME
First Middle Last
Dirk Lems | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Hannie Warmolts | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
519-38-1902 | | 17. INFORMANT
Mrs. Barbara L. Lems | | | | ADDRESS
110 Warren Rd. 21030 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
8199 IMMEDIATE CAUSE (a) AVULSION AND LACERATION OF SKULL
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
8254 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
12 31 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Auto Accident | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.)
STREET | | 21f. LOCATION Street or R.F.D. No.
BALTO. BELMONT | | City or Town
TOWSON | | County
BALTO. | | State
MD. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL
SIGNATURE William A. Pillsbury | | EXAMINER'S
NAME (Type) William A. Pillsbury | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | | | | ADDRESS (Street, City, Town or County)
Baltimore | | 22b. DATE SIGNED
3-17-68 | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Dulaney Valley Cemetery | | 23d. LOCATION (City or Town)
Cockeysville, Md. Balto. | | (County) | | (State) | | |
| 24. FUNERAL DIRECTOR
Wm. Cook-Brooks Towson 1050 York Rd. 21204 | | | | | | 25a. REC'D BY REGISTRAR
MAR 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

03780

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

03780

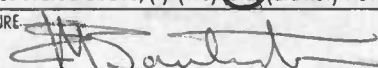
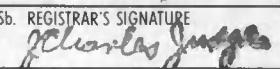
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--|--|--|---|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print)
CHARLES JOSEPH LEONARD | | | 2a. DATE OF DEATH
Month MARCH Day 6 Year 1968 | | | 2b. HOUR 11:15 PM | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MAY 9, 1894 | | 6. AGE (In years last birthday)
73 YRS. | | IF UNDER 1 YEAR
MONTHS OAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | | |
| 10. CITY OR TOWN OF DEATH
TOWSON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABOR | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
ESSEX | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
309 RIVERSIDE DRIVE #21221 | |
| 14. FATHER'S NAME First Middle Last
? ? ? | | | 15. MOTHER'S MAIDEN NAME First Middle Last
? ? ? | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
UNK | | | 16b. SOCIAL SECURITY NO.
215-28-9791 | | 17. INFORMANT
AUGUSTA LEONARD | | | Address
A BOVE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) RESPIRATORY AND CARDIAC FAILURE
153.8
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) METASTATIC CA of the COLON
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
153.8 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
White <input type="checkbox"/> Nat white <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEBRUARY 3, 1968 , to MARCH 6, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 6, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
 | | | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 7, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
EDILBERTO BAUTISTA, M.D. | | | | 22e. ADDRESS
7620 YORK ROAD TOWSON, MD. #21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY
LODGE PARK | | 23d. LOCATION (City or Town) (County) (State)
BALTO. MD. | | | | |
| 24. FUNERAL DIRECTOR
J.G. CONNELLY SONS | | | | ADDRESS
300 MACE | | 25a. REC'D BY REGISTRAR
MAR 11 1968 | | 25b. REGISTRAR'S SIGNATURE
 | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03755

03737

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(Type or print) ESTHER LOUISE LETMATE | | | 2a. DATE OF DEATH
Month 13 Day 68 Year | | | 2b. HOUR
10 M | | | | | |
| 3. SEX
FEMALE | | 4. RACE
Cauc | | 5. DATE OF BIRTH
1/31/99 | | 6. AGE (In years lost birthday)
69 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Balto, Md Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Balto, Md | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Agnes Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during last 12 months, even if terminated.)
Secretary | | | 12b. KIND OF BUSINESS OR INDUSTRY
NA | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7905 Park Heights Ave | | |
| 14. FATHER'S NAME First Middle Last
Jahus A. Letmate | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Kaduck Rose | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
215-09-4902 | | | 17. INFORMANT
Dr. R. Breitenecker - Patient Chart #7 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Severe chronic lung disease
5192
DUE TO, OR AS A CONSEQUENCE OF (b) (pos. radiation pneumonitis)
and gastro-intestinal hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (c) By ulcers of stomach and duodenum
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
5277 acute pericarditis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
yes | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/8 , 19 68 , to 3/13 , 19 68 , that (I) (we) last saw the deceased alive on 3/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
R. Breitenecker M.D. | | | | | | 22c. DATE SIGNED
3/13/68 | | 22d. PHYSICIAN'S NAME (Type)
GP MC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE
3-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md | | | |
| 24. FUNERAL DIRECTOR
Ellsworth Armacost - 4600 Liberty Heights Ave | | | | | | 25a. REC'D BY REGISTRAR
MAR 15 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR
a. M |
| Estelle | | | Lewis | | | March 25, 1968 | | | 6:15 a. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| female | | white | | June 24, 1882 | | | 85 YRS. | | IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U. S. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Catonsville | | | SPRING GROVE STATE HOSP. | | | housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | Balto. | | Essex | | YES | | 361 Townsend Road |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| BIDDERSON | | | | Eliza Bitterson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | | | | | Records: SPRING GROVE STATE HOSPITAL | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
<u>486x</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>493x</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (1) (X) this hospital attended the deceased from <u>Dec. 4</u> , 19 <u>63</u> , to <u>March 25</u> , 19 <u>68</u> , that (X) (we) lost saw the deceased alive on <u>March 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Vincent M. Ruano MD</u> | | | | | | | 22c. DATE SIGNED
3-25-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Vincente M. Ruano, M.D. | | | | | | | 22e. ADDRESS
SPRING GROVE STATE HOSPITAL
Catonsville, Maryland 21228 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 3/27/68 | | OAK LAWN | | BALTO., MD. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
J.G. CONNELLY SONS 300 MACE | | | | | 25a. REGISTRY DATE
MAR 27 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | |

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| NAME | | ADDRESS | | CITY | | STATE | | ZIP | |
|---------------|--|---------------|--|-----------------|--|-------|--|-------|--|
| J. W. Smith | | 123 Main St | | New York | | NY | | 10001 | |
| John Doe | | 456 Elm St | | Los Angeles | | CA | | 90001 | |
| Jane Doe | | 789 Oak St | | Chicago | | IL | | 60601 | |
| Bob Johnson | | 101 Pine St | | Houston | | TX | | 77001 | |
| Alice Brown | | 202 Maple St | | Phoenix | | AZ | | 85001 | |
| Charlie Green | | 303 Birch St | | Philadelphia | | PA | | 19101 | |
| Diana White | | 404 Cedar St | | San Antonio | | TX | | 78101 | |
| Frank Black | | 505 Elm St | | Dallas | | TX | | 75201 | |
| Grace Hall | | 606 Oak St | | San Diego | | CA | | 92101 | |
| Henry King | | 707 Pine St | | Austin | | TX | | 78701 | |
| Ivy Lee | | 808 Maple St | | Jacksonville | | FL | | 32201 | |
| Jack Miller | | 909 Birch St | | Fort Worth | | TX | | 76101 | |
| Karen Wilson | | 1010 Cedar St | | San Jose | | CA | | 95101 | |
| Leo Young | | 1111 Elm St | | Portland | | OR | | 97201 | |
| Mia Adams | | 1212 Oak St | | Seattle | | WA | | 98101 | |
| Noah Baker | | 1313 Pine St | | Denver | | CO | | 80201 | |
| Olivia Carter | | 1414 Maple St | | San Francisco | | CA | | 94101 | |
| Peter Davis | | 1515 Birch St | | Boston | | MA | | 02101 | |
| Quinn Evans | | 1616 Cedar St | | Nashville | | TN | | 37201 | |
| Sam Foster | | 1717 Elm St | | New Orleans | | LA | | 70101 | |
| Tina Gibson | | 1818 Oak St | | San Luis Obispo | | CA | | 93401 | |
| Uma Harper | | 1919 Pine St | | Honolulu | | HI | | 96801 | |
| Victor Ives | | 2020 Maple St | | Salt Lake City | | UT | | 84101 | |
| Wendy Jones | | 2121 Birch St | | Milwaukee | | WI | | 53201 | |
| Xavier King | | 2222 Cedar St | | Indianapolis | | IN | | 46201 | |
| Yara Lee | | 2323 Elm St | | Columbus | | OH | | 43201 | |
| Zoe Miller | | 2424 Oak St | | San Francisco | | CA | | 94101 | |
| Adam Nelson | | 2525 Pine St | | Portland | | ME | | 04101 | |
| Bella Ortiz | | 2626 Maple St | | San Jose | | CA | | 95101 | |
| Caleb Parker | | 2727 Birch St | | New York | | NY | | 10001 | |
| Dora Quinn | | 2828 Cedar St | | Los Angeles | | CA | | 90001 | |
| Ethan Reed | | 2929 Elm St | | Chicago | | IL | | 60601 | |
| Fiona Scott | | 3030 Oak St | | Houston | | TX | | 77001 | |
| Gavin Taylor | | 3131 Pine St | | Phoenix | | AZ | | 85001 | |
| Hannah Vance | | 3232 Maple St | | Philadelphia | | PA | | 19101 | |
| Ian Webb | | 3333 Birch St | | San Antonio | | TX | | 78101 | |
| Julia White | | 3434 Cedar St | | Dallas | | TX | | 75201 | |
| Kevin Young | | 3535 Elm St | | San Diego | | CA | | 92101 | |
| Liam Zane | | 3636 Oak St | | Austin | | TX | | 78701 | |
| Mia Adams | | 3737 Pine St | | Jacksonville | | FL | | 32201 | |
| Noah Baker | | 3838 Maple St | | Fort Worth | | TX | | 76101 | |
| Olivia Carter | | 3939 Birch St | | San Jose | | CA | | 95101 | |
| Peter Davis | | 4040 Cedar St | | Portland | | OR | | 97201 | |
| Quinn Evans | | 4141 Elm St | | Seattle | | WA | | 98101 | |
| Sam Foster | | 4242 Oak St | | Denver | | CO | | 80201 | |
| Tina Gibson | | 4343 Pine St | | San Francisco | | CA | | 94101 | |
| Uma Harper | | 4444 Maple St | | Boston | | MA | | 02101 | |
| Victor Ives | | 4545 Birch St | | Nashville | | TN | | 37201 | |
| Wendy Jones | | 4646 Cedar St | | New Orleans | | LA | | 70101 | |
| Xavier King | | 4747 Elm St | | San Luis Obispo | | CA | | 93401 | |
| Yara Lee | | 4848 Oak St | | Honolulu | | HI | | 96801 | |
| Zoe Miller | | 4949 Pine St | | Salt Lake City | | UT | | 84101 | |
| Adam Nelson | | 5050 Maple St | | Milwaukee | | WI | | 53201 | |
| Bella Ortiz | | 5151 Birch St | | Indianapolis | | IN | | 46201 | |
| Caleb Parker | | 5252 Cedar St | | Columbus | | OH | | 43201 | |
| Dora Quinn | | 5353 Elm St | | San Francisco | | CA | | 94101 | |
| Ethan Reed | | 5454 Oak St | | Portland | | ME | | 04101 | |
| Fiona Scott | | 5555 Pine St | | San Jose | | CA | | 95101 | |
| Gavin Taylor | | 5656 Maple St | | New York | | NY | | 10001 | |
| Hannah Vance | | 5757 Birch St | | Los Angeles | | CA | | 90001 | |
| Ian Webb | | 5858 Cedar St | | Chicago | | IL | | 60601 | |
| Julia White | | 5959 Elm St | | Houston | | TX | | 77001 | |
| Kevin Young | | 6060 Oak St | | Phoenix | | AZ | | 85001 | |
| Liam Zane | | 6161 Pine St | | Philadelphia | | PA | | 19101 | |
| Mia Adams | | 6262 Maple St | | San Antonio | | TX | | 78101 | |
| Noah Baker | | 6363 Birch St | | Dallas | | TX | | 75201 | |
| Olivia Carter | | 6464 Cedar St | | San Diego | | CA | | 92101 | |
| Peter Davis | | 6565 Elm St | | Austin | | TX | | 78701 | |
| Quinn Evans | | 6666 Oak St | | Jacksonville | | FL | | 32201 | |
| Sam Foster | | 6767 Pine St | | Fort Worth | | TX | | 76101 | |
| Tina Gibson | | 6868 Maple St | | San Jose | | CA | | 95101 | |
| Uma Harper | | 6969 Birch St | | Portland | | OR | | 97201 | |
| Victor Ives | | 7070 Cedar St | | Seattle | | WA | | 98101 | |
| Wendy Jones | | 7171 Elm St | | Denver | | CO | | 80201 | |
| Xavier King | | 7272 Oak St | | San Francisco | | CA | | 94101 | |
| Yara Lee | | 7373 Pine St | | Boston | | MA | | 02101 | |
| Zoe Miller | | 7474 Maple St | | Nashville | | TN | | 37201 | |
| Adam Nelson | | 7575 Birch St | | New Orleans | | LA | | 70101 | |
| Bella Ortiz | | 7676 Cedar St | | San Luis Obispo | | CA | | 93401 | |
| Caleb Parker | | 7777 Elm St | | Honolulu | | HI | | 96801 | |
| Dora Quinn | | 7878 Oak St | | Salt Lake City | | UT | | 84101 | |
| Ethan Reed | | 7979 Pine St | | Milwaukee | | WI | | 53201 | |
| Fiona Scott | | 8080 Maple St | | Indianapolis | | IN | | 46201 | |
| Gavin Taylor | | 8181 Birch St | | Columbus | | OH | | 43201 | |
| Hannah Vance | | 8282 Cedar St | | San Francisco | | CA | | 94101 | |
| Ian Webb | | 8383 Elm St | | Portland | | ME | | 04101 | |
| Julia White | | 8484 Oak St | | San Jose | | CA | | 95101 | |
| Kevin Young | | 8585 Pine St | | New York | | NY | | 10001 | |
| Liam Zane | | 8686 Maple St | | Los Angeles | | CA | | 90001 | |
| Mia Adams | | 8787 Birch St | | Chicago | | IL | | 60601 | |
| Noah Baker | | 8888 Cedar St | | Houston | | TX | | 77001 | |
| Olivia Carter | | 8989 Elm St | | Phoenix | | AZ | | 85001 | |
| Peter Davis | | 9090 Oak St | | Philadelphia | | PA | | 19101 | |
| Quinn Evans | | 9191 Pine St | | San Antonio | | TX | | 78101 | |
| Sam Foster | | 9292 Maple St | | Dallas | | TX | | 75201 | |
| Tina Gibson | | 9393 Birch St | | San Diego | | CA | | 92101 | |
| Uma Harper | | 9494 Cedar St | | Austin | | TX | | 78701 | |
| Victor Ives | | 9595 Elm St | | Jacksonville | | FL | | 32201 | |
| Wendy Jones | | 9696 Oak St | | Fort Worth | | TX | | 76101 | |
| Xavier King | | 9797 Pine St | | San Jose | | CA | | 95101 | |
| Yara Lee | | 9898 Maple St | | Portland | | OR | | 97201 | |
| Zoe Miller | | 9999 Birch St | | Seattle | | WA | | 98101 | |

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VR A15 (4)
30M REV. 7-68

| <div style="display: flex; justify-content: space-between;"> <div> <p>03757</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</p> </div> <div> <p>03739</p> </div> </div> | | | | | | | | | | | |
|---|--|------------------------------|--|---|------------------------------------|---|--|--|-----------------------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Aubrey | | | O. Little | | | Month 3 Day 26 Year 68 | | | 12 A M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | Caucasian | | Feb. 8, 1887 | | | 81 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Canada | | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | G.B.M.C. | | | accountant | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md | | | Balto | | Cockeysville | | | | 16 St elmo Ct. | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Richard Little | | | Ellen Eberts | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| No | | | 375-037687 | | Mrs Edna L. Little 16 St elmo Ct | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease with</u>
<u>410.9</u> DUE TO , OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u>
(b) <u>extensive myocardial infarcts</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>Pulmonary emphysema</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 3/9/68 | | | Acute appendicitis | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>68</u> , to <u>3/26</u> , 19 <u>68</u> , that (I) (we) lost
saw the deceased alive on <u>3/26</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | 3/26/68 | | | | | |
| Rudiger Breiteneker, M.D. | | | 6701 N. Charles Street | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Cremation | | | 3-27-68 | | Greenmount Crematory | | Baltimore Md. | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. Cook-Brooks Towson Inc | | | 1050 York rd | | | MAR 28 1968 | | J Charles Judge | | | |

0373

0373

Handwritten signature

FOR STATE HEALTH DEPT

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|---|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | |
| JOHN | | A. | | LITTLE, Jr. | | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year
<input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 1968 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Male | Negro | 7/26/27 | | 40 YRS | | MONTHS DAYS | | HOURS MIN. | |
| 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | 2c. DATE PRONOUNCED DEAD | |
| North Carolina | | USA | | WIDOWED | | DIVORCED | | March Day 4, Year 1968 | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Sparrows Point | | Plant Dispensary | | Steel Worker | | Steel | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3509 Berwyn Avenue | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | |
| JOHN | | A. | | LITTLE, SR. | | MABLE LITTLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| | | 212-22-1779 | | Mrs. Doris Little | | 1022 Carlton | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gunshot Wound of Chest Involving The Heart, 955X
(b) and Aorta.
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 976X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. P.M. 3/4/ 19 68 | | shot self in chest | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | factory | | | | Baltimore, Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | Werner U. Spitz, M.D. | | CHIEF MEDICAL EXAMINER | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER | | | | 3/5/68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-8-68 | | Baltimore Nat'l Cem. | | Baltimore, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| MORTON & DYETT F.H. | | | | 1701 Laurens Street | | MAR 6 1968 | | Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

| 03753 | | | | 03741 | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| First Middle Last
John Robert LOCKWOOD | | | | Month Day Year
3 27 68 | | | | 4:10 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | | White | | 9/13/65 | | 2 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Owings Mills | | Rosewood State Hospital | | Dependent | | none | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Kent | | Millington | | YES | | Box 211 | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| John Howard Lockwood | | | | Esther Amy Ridgely | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| no | | | | none | | Rosewood Records, Owings Mills, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
7439
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Right cerebral atrophy
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | 12 days
since birth | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 7531 Profound mental retardation | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from 3/13 , 19 68 , to 3/27 , 19 68 , that (X) (we) last saw the deceased alive on 3/27 , 19 68 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. DATE SIGNED | |
| D. Crosby Greene M.D. | | 3/29/68 | | D. CROSBY GREENE, M.D. | | Rosewood State Hospital Owings Mills, Md. 21117 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Mar. 30, 1968 | | Busic Cemetery | | Rural Templeville, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| Edward Fellows Millington, Md. | | | | APR 1 - 1968 | | Charles J. J... | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MD. STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03760

03742

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) James Albert Lybrund | | | 2a. DATE OF DEATH
Month March Day 18 Year 1968 | | | 2b. HOUR
8A M | | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
4/8/17 1888 | | 6. AGE (In years lost, birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7128 Railway Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LATHER | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
7128 Railway Ave. | |
| 14. FATHER'S NAME First Middle Last
Chrispter Lybrund | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lillie Mathwev Lybrund | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
yes WWI & II | | | 16b. SOCIAL SECURITY NO.
217-20-9795 | | 17. INFORMANT Address
M.S. Lybrund same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CUA
4120
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Hypertensive Cardiovascular
DUE TO, OR AS A CONSEQUENCE OF
(c)
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
443X | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10 , 19 68 to 3/18 , 19 68 , that (I) (we) last saw the deceased alive on 3/18 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Theo C. Patterson | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/18/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
T.C. Patterson, M.D. | | | | 22e. ADDRESS
Dundalk, Maryland 21222 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/21/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Baltimore Co., Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Walter Brooks Realty Inc. Dundalk, Md. | | | | 25a. REC'D BY REGISTRAR
DATE Mar 22 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1M

03761

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03743

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) MR. JAMES PATRICK LYNCH | | | 2a. DATE OF DEATH
Month MARCH Day 23 Year 1968 | | | 2b. HOUR
6 PM | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
8-29-1887 | | 6. AGE (In years lost birthday)
80 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Mount Wilson, Balto. Co., Md. | |
| 10. CITY OR TOWN OF DEATH
Mount Wilson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Mt. Wilson State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
TYPIST | | 12b. KIND OF BUSINESS OR INDUSTRY
OFFICE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
TOWSON | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
967 FAIRMOUNT AVE. | | | | | | | |
| 14. FATHER'S NAME
First JAMES PETER Middle LYNCH Last LYNCH | | | 15. MOTHER'S MAIDEN NAME
First MARY Middle GAIERTY Last GAIERTY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO | | 16b. SOCIAL SECURITY NO.
218-52-0590 | | 17. INFORMANT
Address Records, Mt. Wilson State Hospital | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASPIRATION OF GASTRIC CONTENTS
492X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) PULMONARY EMPHYSEMA
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINS
YRS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5271 Mod. Advanced Pulmonary Tuberculosis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
YRS | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-2- , 1966, to 3-23 , 1968, that (I) (we) lost saw the deceased alive on 3-23- 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
W Newcomer | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/23/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
William Newcomer, M.D. | | 22e. ADDRESS
Mount Wilson, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
H. W. Jenkins & Sons Co. | | ADDRESS
4905 York Rd. Balto. 12, Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

12584

MADE IN U.S.A.

10120

MADE IN U.S.A.

MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 44
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|------------------------------|---|---|--|---|--|---|---|---------|-------|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| Adam | | - | | MACH, MA | Month 3 Day 20 Year 68 | | 8:43 ^a M | | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| Male | White | | 3/27/25 | | 42 YRS. | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | U.S.A. | | | | Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Owings Mills | | Rosewood State Hospital | | Dependent | | none | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | | | | |
| Maryland | | | | Baltimore | | 2205 Duker Court | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Adam | | | | Mach, Sr. | Madalene | | | | Borgula | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | Address | |
| no | | none | | Rosewood Records, Owings Mills, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia Bilateral.</u>
<u>486x</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>490x</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County | State |
| 22a. I certify that (s) (this hospital) attended the deceased from <u>3/30</u> , 19 <u>68</u> , to <u>3/20</u> , 19 <u>68</u> , that (he) (we) last
saw the deceased alive on <u>3/20</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (s) (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Esteban V. Diaz, M.D.</u> DEGREE | | | | | | ATTENDING
PHYS. <input type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>3/20/68</u> | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| Esteban V. Diaz, M.D. | | | | Rosewood St. Hosp., Owings Mills, Md. | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| BURIAL | | MAR. 23 1968 | | HOLY ROSARY CEMETERY | | BALTIMORE | | | MD. | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. RECD BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| RAYMOND L. KACZOROWSKI | | | | 2525 FLEET ST. | | DATE MAR 27 1968 | | <u>[Signature]</u> | | |

42750

STATE OF TEXAS

1911

IN SENATE, FEBRUARY 1, 1911.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1910.

COMMISSIONER OF THE GENERAL LAND OFFICE.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1910.

COMMISSIONER OF THE GENERAL LAND OFFICE.

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COMMISSIONER OF THE GENERAL LAND OFFICE.

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1910.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 415 (M)
30M REV. 7/68

| <div>03763</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03745</div> | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|---|------------------------------|
| 1. DECEASED-NAME
(Type or print)
First Middle Last
JAMES JOSEPH MAGEE | | | | | | 2a. DATE OF DEATH
Month Day Year
March 24 1968 | | | 2b. HOUR
a
6:10 M | | |
| 3. SEX
Male | | 4. RACE
white | | 5. DATE OF BIRTH
August 1, 1892 | | | 6. AGE (In years last birthday)
75 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson 21204 | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Baltimore | | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
319 Wyman Park Drive 21211 | |
| 14. FATHER'S NAME First Middle Last
JAMES MAGEE | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
SARAH JENNINGS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, na, ar, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address
FRANK C. HORIGAN 6301 N. CHARLES ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heart failure
4249
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) chronic pulmonary insufficiency.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4213 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 24, 1968 , to March 24, 1968 , that (I) (we) lost the deceased on March 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
ICilliani | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
March 24, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Ines Cilliani, M.D. | | | | | | 22e. ADDRESS
7620 York Road, Towson, Maryland 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
MARCH 27/68 | | 23c. NAME OF CEMETERY OR CREMATORY
CATHEDRAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MD. | | | | | |
| 24. FUNERAL DIRECTOR
H. W. MEARS & SON 805 N. CALVERT ST. | | | | | | 25a. RECEIVED BY REGISTRAR
DATE MAR 29 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

MEDICAL CERTIFICATION

82783



U. S. DEPT. OF JUSTICE

CHIEF, BUREAU OF INVESTIGATION

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (4)
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | |
|--|--|--|---|---|-----------------------------------|
| 03764 | | | 03746 | | |
| 1. DECEASED-NAME (Type or print)
Dorothy Virginia Mahan | | | 2a. DATE OF DEATH
3-30-68 Month Day Year | | |
| 3. SEX
Female | | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
1-8-11 |
| 6. AGE (In years last birthday)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
St. Joseph's Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | |
| 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3002 Southern Ave. | | | |
| 14. FATHER'S NAME First Middle Last
Charles Cook | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Blanche Slater | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown
No | | 16b. SOCIAL SECURITY NO.
705052479 | | 17. INFORMANT Address
James G. Mahan, 3002 Southern Ave. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Heart Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Few minutes
2 years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from February, 1966 , to March, 1968 , that (I) (we) last saw the deceased alive on Mar. 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Loy M. Zimmerman, M.D. | | 22c. DATE SIGNED
3/30, 68 | | 22d. PHYSICIAN'S NAME (Type)
Loy M. Zimmerman, M.D. | |
| 22e. ADDRESS
3202 Harford Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
4-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Pk. | |
| 23d. LOCATION (City or Town) (County) (State)
Balto., Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc., 5305 Harford Rd. | | 25a. REC'D BY REGISTRAR
DATE APR 1 - 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | |
|--|--|---|---|---|--|---|---|---|-------------------|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2c. DATE OF DEATH | | 2b. HOUR | |
| EVALYN LYDIA MALIN | | | | | | MARCH 25, 1968 | | 5:30 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR | |
| FEMALE | | WHITE | | SEPT. 15, 1884 | | 85 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| PENNA. | | U.S.A. | | | | BALTIMORE | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| TOWSON | | PRESBYTERIAN HOME | | PRACTICAL NURSE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission, STATE) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | | BALTIMORE | | | | 34 E. 25TH ST | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| SAMUEL OGDEN MALIN | | | | | | HANNAH HARDCASTLE | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | 17. INFORMANT Address | | | |
| NO | | | 219-30-5938 | | | PRESBYTERIAN HOME OF MD. TOWSON, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PARKINSON DISEASE</u>
<u>342X</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>YEARS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>350X GENERALIZED ARTERIO SCLEROSIS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>60</u> , to <u>MARCH 25</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>MARCH 20</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>S. J. Venable M.D.</u> | | | | DEGREE ATTENDING
PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. | | 22c. DATE SIGNED
<u>3-26-68</u> | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | DR. S.J. VENABLE | | 22e. ADDRESS
<u>7215 YORK RD.</u> | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| BURIAL | | 3-27-68 | | DRUID RIDGE | | PIKESVILLE, MD. | | | |
| 24. FUNERAL DIRECTOR
ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| MITCHELL WIEDEFELD HOME, INC.
6500 YORK RD. BALTIMORE, MD. | | | | MAR 28 1968 | | <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| <div style="display: flex; justify-content: space-between;"> 03766 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03748 </div> | | | | | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|---|--|------------------------------------|--|
| 1. DECEASED-NAME
(Type or print) Alexander | | | First P. | | Middle P. | | Last Malinowski | | 2a. DATE OF DEATH
Month March Day 12 Year 1968 | | 2b. HOUR
8:30 P.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 7, 1906 | | | 6. AGE (In years lost birthday)
62 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Dundalk | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
7928 St. Gregory Drive | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Self-employed | | | 12b. KIND OF BUSINESS OR INDUSTRY
Barber | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Dundalk | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
7928 St. Gregory Drive | | | | |
| 14. FATHER'S NAME
First Vincent Middle P. Last Malinowski | | | 15. MOTHER'S MAIDEN NAME
First Catherine Middle Last ? | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO.
218-10-9947 | | 17. INFORMANT (Wife) Dundalk, Md. Drive
Mrs. Gertrude Malinowski, 7928 St. Gregory | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) PULMONARY HEMORRHAGE
1621
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of the lungs
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 MO | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
163X | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1 , 19 67 , to Nov 12 , 19 68 , that (I) (we) last saw the deceased alive on Nov 5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Stephen C. Mackowiak DEGREE M. D. | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3/13/68 | |
| 22d. PHYSICIAN'S NAME (Type) Stephen C. Mackowiak | | | | | | | | | | 22e. ADDRESS
6714 Holabird Ave. Dundalk, Md. 21222 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/16/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Rosary Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR
John J. Duda, 7922 Wise Ave. Dundalk, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 14 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Young | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
30M REV. 1-2-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First
CARL | | | Middle
H. | | | Last
MARSHALL | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
3/3/93 | | | 20. DATE OF DEATH
Month March Day 25 Year 68 2b. HOUR
6:15A M | | |
| 70. BIRTHPLACE (State or foreign)
GERMANY | | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. CITIZEN | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
BALTIMORE | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VET. ADM. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
GUARD | | | 12b. KIND OF BUSINESS OR INDUSTRY
HOSPITAL | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
HOWARD | | | 13c. CITY OR TOWN
BALTIMORE | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME First
UNKNOWN | | | Middle
UNKNOWN | | | Last
UNKNOWN | | | 15. MOTHER'S MAIDEN NAME First
UNKNOWN | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES (If yes give war or dates of service) WW I | | | 16b. SOCIAL SECURITY NO.
212 22 17 14 | | | 17. INFORMANT
CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD. | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINOMA HEAD OF PANCREAS WITH METASTASIS
157.0 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 157.0
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
7 MONTHS | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
GARCINOMA OF PROSTATE | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 3/4/68 , 19____, to 3/25/68 , 19____, that (a) (we) last saw the deceased alive on 3/25/68 , 19____, and that (a) (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>George C. McElpatrick M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED
3/25/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
GEORGE C. MC ELPATRICK, M. D. | | | | | | | | | 22e. ADDRESS
VAH FORT HOWARD, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | |
| 24. FUNERAL DIRECTOR
<i>G. H. H. H.</i> | | | ADDRESS
KIRKLEY FUNERAL HOME
GLEN BURNIE, MARYLAND | | | 25a. REC'D BY REGISTRAR
MAR 27 1968 | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

05700

05700

| NAME | DATE | REMARKS | INITIALS | STATUS |
|---------------|----------|----------------------|----------|------------|
| JOHN H. BROWN | 10/15/50 | Admitted to hospital | JHB | Inpatient |
| JOHN H. BROWN | 10/15/50 | Discharged | JHB | Outpatient |
| JOHN H. BROWN | 10/15/50 | Admitted to hospital | JHB | Inpatient |
| JOHN H. BROWN | 10/15/50 | Discharged | JHB | Outpatient |

JOHN H. BROWN, 10/15/50, Admitted to hospital, 10/15/50, Discharged, 10/15/50, Admitted to hospital, 10/15/50, Discharged.

JOHN H. BROWN

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05700

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JOHN H. BROWN, 10/15/50, Admitted to hospital, 10/15/50, Discharged, 10/15/50, Admitted to hospital, 10/15/50, Discharged.

JOHN H. BROWN

JOHN H. BROWN

JOHN H. BROWN

JOHN H. BROWN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03768

CERTIFICATE OF DEATH

03750

| | | | | | | | | | | |
|---|--|--|--|---|----------------|---|---|--------------------------------|---|-----------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
CAROLYN | | Middle
LAVIECE | Last
MASLIN | | 2a. DATE OF DEATH
MARCH Month 4 Day 1968 | | 2b. HOUR
1:35 ^A _M | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
April 10, 1938 | | 6. AGE (In years
last birthday)
29 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 1D. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
St. Joseph Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY
Social Security | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
3205 St. Paul St. | | | | |
| 14. FATHER'S NAME First Middle Last
Paul Thomas Maslin Sr. | | 15. MOTHER'S MAIDEN NAME First Middle Last
Laviece Roszell | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) (If yes give war or dates of service)
No | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Paul T. Maslin--514 Shipley Road-21090 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
2509
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <u>Diabetic glomerulosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
260X | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from February 2, 1968, to March 4, 1968, that (I) (we) last
saw the deceased alive on March 4, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
✓ Gillian | | DEGREE | | ATTENDING
PHYS. | | MED.
DIRECTOR | | STAFF
PHYS. | | 22c. DATE SIGNED
March 4, 1968 |
| 22d. PHYSICIAN'S
NAME (Type) | | Ines Gilliani, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY
London PR Cem. | | 23d. LOCATION (City or Town)
BALTO. | | (County)
Md. | | (State) |
| 24. FUNERAL DIRECTOR
E.S. MacNeil | | ADDRESS
Catonville Md. | | 25a. REC'D BY REGISTRAR
DATE MAR 6 1968 | | 25b. REGISTRAR'S SIGNATURE
John J. Jones | | | | |

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A 15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print)
First: RALPH Middle: ROBERT Last: MASON | | | 2a. DATE OF DEATH
Month: MARCH Day: 30, 1968 Year: 1968 | | | 2b. HOUR
5:50A M | | | |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
3/10/17 | | 6. AGE (In years last birthday)
51 YRS. | | IF UNDER 1 YEAR
MONTHS: DAYS: HOURS: MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH
FORT HOWARD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
VETERAN'S ADMIN. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
CAB DRIVER | | 12b. KIND OF BUSINESS OR INDUSTRY
TRANSPORTATION | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
BALTIMORE | | 13c. CITY OR TOWN
BALTIMORE | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
2332 McCULLOH STREET | |
| 14. FATHER'S NAME First: ALFRED Middle: -- Last: MASON | | 15. MOTHER'S MAIDEN NAME First: SALLY Middle: -- Last: ROCHESTER | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16b. SOCIAL SECURITY NO.
212 09 34 35 | | 17. INFORMANT Address
CLINICAL RECORDS, VAH, FT. HOWARD, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA OF THE CECUM</u>
1530 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) -- --
DUE TO, OR AS A CONSEQUENCE OF
(c) -- --
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 YEAR | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
1530 -- -- | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from FEB 20, 1968, to MAR 30 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAR 30 1968, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Alfonso A. Lopez | | 22c. DATE SIGNED
3/30/68 | | 22d. PHYSICIAN'S NAME (Type)
ALFONSO A. LOPEZ, M.D. | | | | 22e. ADDRESS
FORT HOWARD VAH, FORT HOWARD, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
4-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY
BALTO. NATIONAL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR
MORTON & DYETT | | 25a. REC'D BY REGISTRAR
DATE APR 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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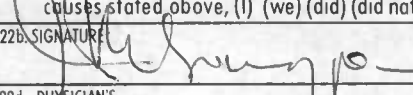
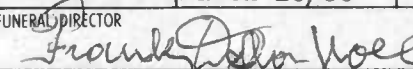

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|---|---|---|---|--|--|
| <div> <div>5</div> <div>03770</div> <div>item 70 File G399 3/27/68 kk</div> <div>03752</div> </div> | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Middle Last | | | | | Month Day Year | | | A M | | |
| ALFRED MATANI | | | | | March 14th, 1968 | | | 3:30 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR | | |
| Male | | White | | February 24, 1896 | | 72 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Italy | | USA | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Towson | | | St. Joseph Hospital | | | retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Baltimore | | Baltimore | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 3021 Lavender Ave. 21234 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Sabatino Matani | | | Filomena Orsini | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| | | | 215-32-1578 | | Maria Matani (Wife) 3021 Lavender Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> | | | | | | | | | | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) <u>Acute Myocardial Infarction</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) <u>Arteriosclerotic Cardiovascular Disease</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| 4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 12</u> , 19 <u>68</u> , to <u>March 14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>March 14</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | 22c. DATE SIGNED | | |
|  | | | | | | | | March 14, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | | |
| Jaime Singzon, M.D. | | | | 7620 York Rd., Towson, Md. 21204 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| | | March 18/68 | | Holy Redeemer Cemetery | | 4430 Belair Rd. Balt. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
|  | | | | 322 S. High St. | | MAR 15 1968 | |  | | |

03730

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03753

| | | | | | |
|--|--|--|---|---|---|
| 1. DECEASED-NAME (Type or print) George F. May | | | 2a. DATE OF DEATH 3 Month 2 Day 68 Year | | 2b. HOUR 1 p. M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 9-14-99 | | 6. AGE (In years lost birthday) 68 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Baltimore Md. | | |
| 10. CITY OR TOWN OF DEATH Randallstown, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Baltimore County Gen. Hos. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bricklayer | 12b. KIND OF BUSINESS OR INDUSTRY construction |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Balto. | 13c. CITY OR TOWN Randallstown | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER 3703 Offutt Rd. |
| 14. FATHER'S NAME First George Middle F. Last May Sr. | | | 15. MOTHER'S MAIDEN NAME First Johnna Middle Pausch Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes (If yes give war or dates of service) WW I | | 16b. SOCIAL SECURITY NO. 215-10-3838 | 17. INFORMANT Address Mrs Nellie S. May 3703 Offutt Rd. Randallstown | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 441.2 Ruptured aneurysm of abd. aorta
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral AS Disease, Acute C.V.A.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Some generalized atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF OLD CVA
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
YRS | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
451X | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1 , 19 68 , to 3-2 , 19 68 , that (I) (we) last saw the deceased alive on 3-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Angelita A. Topacio DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 2-2-68 | |
| 22d. PHYSICIAN'S NAME (Type) ANGELITA TOPACIO, MD. | | 22e. ADDRESS BC 344 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 3/5/68 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial | | 23d. LOCATION (City or Town) Balto. 34 (County) Balto (State) Md. | |
| 24. FUNERAL DIRECTOR Spring Byers ADDRESS 8728 Liberty Rd. Randallstown Md. | | 25a. REC'D BY REGISTRAR MAR 5 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA-15ME, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

Items 18 22a film 399
4-17-68 mt
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
037772
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03754

| | | | | | | | | | | | | | |
|---|---------|---|--|---|--------------------------------|---|--------------------------------|---|--|----------------|----------|---|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 20. DATE KNOWN
OF ESTI-
DEATH MATED | | Month Day Year | | 2b. HOUR | |
| ALBERT | | TIMOTHY | | McCOY | | | | March 14, 1968 | | | | 9:00 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
Month Day Year | | 2d. HOUR | | |
| Male | White | 5/4/1906 | | 46 YRS. | | | | | March 14, 1968 | | 9:00 PM | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| MARYLAND | | U.S.A. | | | | Baltimore | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | | | | |
| Essex | | 129 Poplar Road | | Cook | | Food | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Baltimore | | Essex | | | | 129 Poplar Road | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | |
| HARRY A. McCOY | | MAUDE | | BYRON | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT | | ADDRESS | | | | | | | |
| NO | | 919-14-9536 | | JOHN F. McLUCKAS | | 8112 BLETZER Rd. 21222 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a).
stating the underlying cause
lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4221 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>Ronald N. Kornblum</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
3-15-68 | | | | | |
| EXAMINER'S
NAME (Type) Ronald N. Kornblum, M.D. | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | | 23b. DATE
3/18/1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
OAK LAWN | | | | | |
| 24. FUNERAL DIRECTOR
W. Evelyn Bradley, Dundalk, Md | | | | 23d. LOCATION (City or Town) (County) (State)
BALTO. Co. Md | | | | 25a. REC'D BY REGISTRAR
DATE MAR 18 1968 | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. M. Jones | | | | | | | | | |

30754

02773

NO. 100
MAY 1964

UNITED STATES DEPARTMENT OF AGRICULTURE
NATIONAL BUREAU OF PLANT INDUSTRY

1964

1964

X



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| Item 18-2a film 399 | | | | | | | | | |
|--|--|----------------------|---|-----------------------------|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 03773 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 03755 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) MYRTLE | | | First Middle Lost | | | 20. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year March 14, 1968 | | | 2b. HOUR 9:00 |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH (?) | | 6. AGE (In years last birthday) 70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) VIRGINIA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Baltimore |
| 10. CITY OR TOWN OF DEATH Essex | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 129 Poplar Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Baltimore | | | 13c. CITY OR TOWN Essex | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME First Middle Lost UNK | | | 15. MOTHER'S MAIDEN NAME First Middle Lost UNK | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO. 218-58-3601 | | | 17. INFORMANT ADDRESS JOHN F. McLUCAS - 8112 BLETZER RD. 21222 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Exposure
901X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
9320 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 3 14 1968 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Subject found in house also frozen | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | | 21f. LOCATION Street or R.F.D. No. City or Town County State Essex Balto Md | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | |
| ACTUAL SIGNATURE Ronald N. Kornblum | | | EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 3-15-68 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 3/18/1968 | | 23c. NAME OF CEMETERY OR CREMATORY OAK LAWN | | 23d. LOCATION (City or Town) (County) (State) BALTO. Co., Md. | | |
| 24. FUNERAL DIRECTOR W. Brooks Doolley, Dundalk, Md. | | | | | | 25a. REC'D BY REGISTRAR MAR 18 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03756

Item 03774 G398 3/15/68 KK

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | |
|---|---------|--|--------|---|---|---|---------------------------|---|-----------------------------------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR |
| JAMES. | | | M | McDEVITT | 3-5-1968 | | 3 | 5 | 1968 | 10:00 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS | | 2c. DATE PRONOUNCED DEAD
Month | |
| W/M | White | 3-20-15 | | 5-9 YRS. | | | | | 3 5 Year 1968 11:55 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Philadelphia | | U.S.A. | | | | BALTIMORE | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| BALTO | | SPARROWSPT-HOSP. | | WEIGHT-MASTER | | BETH STEEL | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD | | BALTO. | | | | | | 308-ENDSLEIGH-AVE #20 | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| John | | | | McDevitt | Anna | | | | Cavanaugh | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | 21220 | | |
| Yes | | W.W. 11 | | 184-10-1526 | | Mrs Mary E. McDevitt | | 308 Endsleigh Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
410.9
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 Exogenous obesity | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | THEO. C. PATTERSON | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | THEO. C. PATTERSON | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 3/5/68 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 3-9-1968 | | Gardens of Faith Cemetery | | Baltimore | | Co. | | Md. |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Lassahn Funeral Home | | 7401 Baker Road | | 36 | | MAR 11 1968 | | Charles Jones | | |

03754

03754

03754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|---|--|--------------------------------|--|
| 03775 | | | | | | 03757 | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | First
ANNA | | Middle | | Last
MCDONALD | | 2a. DATE OF DEATH
Month Day Year
March 2, 1968 | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
11-2-1900 | | | 6. AGE (In years
lost birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Catonsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Summit Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Retired | | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
707 Yale Avenue | | |
| 14. FATHER'S NAME
First Middle Last
Joseph Powers | | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Bridget Burke | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
217-24-2047 | | 17. INFORMANT
Address
Mr. William E. Phillips, 707 Yale Ave., 21229 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Respiratory Failure</u>
1951
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Dehydration & Malnutrition</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Carcinoma of Pelvis</u>
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
1992 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>2 Feb.</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>2 Feb.</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>William J. Bryson MD</u> | | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>4 Feb 68</u> | | | |
| 22d. PHYSICIAN'S
NAME (Type) Dr. William J. Bryson | | | | | | 22e. ADDRESS
4605 Edmondson Avenue | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
BURIAL | | | 23b. DATE
3-6-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Maryland | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
Howard H. Hubbard, 4107 Wilkens Ave. 21229 | | | | | | 25a. REC'D BY REGISTRAR
MAR 6 1968 | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jones</u> | | | |

03457

0852

THE UNIVERSITY OF CHICAGO

U.S. DEPARTMENT OF AGRICULTURE

[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03776

03758

| | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED-NAME
(Type or print)
Collette Barbara McDonald | | | 2a. DATE OF DEATH
Month March Day 19 Year 1968 | | | 2b. HOUR
10:45 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
November 18, 1907 | | 6. AGE (In years
last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Baltimore | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
St. Joseph | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Maryland | | | 13b. COUNTY
BALTO | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
722 Walker Avenue | |
| 14. FATHER'S NAME First Middle Last
Michael Pfaff | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Clara S. Petri | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
Mrs. Collette Nickol (Same) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>B.I. Bleeding -</u>
533.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) <u>Probable ulcer</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 hrs.
? | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5420 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<i>Lawrence M. Serra</i> MD | | | | | DEGREE ATTENDING
PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
3-19-68 | | | |
| 22d. PHYSICIAN'S
NAME (Type)
Lawrence M. Serra, M.D. | | | | | 22e. ADDRESS
11 E. Chase Street #21202 | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
3/23/68. | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Redeemer Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | 25a. REC'D BY REGISTRAR
DATE MAR 21 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

03124

RECEIVED OF DEPT

03124

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(Name)

Mrs. Collette (Name)

X

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1000

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | |
|--|-------------------------|--|---|---|
| 1. DECEASED-NAME
(Type or print)
Leonard S. McGlothlin | | 2a. DATE OF DEATH
Month March Day 5 Year 1968 | | 2b. HOUR
11:35 AM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
April 21, 1917 | | 6. AGE (In years last birthday)
50 YRS. |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH
Baltimore, Md. | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Doctor (Physical Therapist) |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | 13c. CITY OR TOWN
Towson | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 13e. STREET AND NUMBER
1420 E. Joppa Rd. | | | | |
| 14. FATHER'S NAME First Middle Last
John P. McGlothlin | | 15. MOTHER'S MAIDEN NAME First Middle Last
Nellie J. McGlothlin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
221-07-4868 | | 17. INFORMANT Address
Mrs. Doris C. McGlothlin (Same) |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Spontaneous intra-cerebral hemorrhage
4319
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
331X | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/31 , 19 68 , to 3/5 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE
Ramon P. Lopez DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED
March 5, 1968 |
| 22d. PHYSICIAN'S NAME (Type)
Ramon P. Lopez, M.D. | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
3/9/68. | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Rolandsville, Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Leonard J. Ruck, Inc. Balto. Md. 21214 | | 25a. REC'D BY REGISTRAR
DATE MAR 6 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] |

1. Name of the person or organization to whom the property is being transferred

2. Address of the person or organization to whom the property is being transferred

3. Description of the property being transferred

4. Date of the transfer

5. Signature of the person or organization transferring the property

6. Signature of the person or organization receiving the property

7. Name of the person or organization receiving the property

8. Address of the person or organization receiving the property

9. Description of the property being transferred

10. Date of the transfer

11. Signature of the person or organization transferring the property

12. Signature of the person or organization receiving the property

13. Name of the person or organization receiving the property

14. Address of the person or organization receiving the property

15. Description of the property being transferred

16. Date of the transfer

17. Signature of the person or organization transferring the property

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in ~~the~~ funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|------------------------------|--|--|------------------------------------|---|---|--|--|--|--------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | |
| ROMAINE LeMOYNE McLANAHAN | | | | | | | | | Month 3- Day 1- Year 68 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 2b. HOUR | | | |
| Female | | White | | 12-26-1870 | | | 97 YRS. | | 5:10 PM | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Illinois | | USA | | | | Baltimore Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Owings Mills | | | Caves Rd. | | | Homemaker | | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | | Balto. | | Owings Mills | | | | Caves Rd. | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | |
| John Valculon LeMoyne | | | | | | | | | Julia Murray | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | |
| No | | | 218-09-3490 | | | Frances C. Taliaferro | | | Above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | | | | | | 48 hours | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arterio-sclerosis</u> | | | | | | | | | | 10 years | | |
| (c) | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County State | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 1960, to Mar 4, 1968, that (I) (we) last saw the deceased alive on Mar 4, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Palmer F. C. Williams MD</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Mar 5, 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Palmer F. C. Williams | | | | | | 22e. ADDRESS Linson Rd., Balto., Co., Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 3-7-68 | | St. Thomas' | | | Garrison Forest | | Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd., Balto. | | | | | | 25a. REC'D BY REGISTRAR DATE MAR 7 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div>03775</div> <div> <div>MD</div> <div>03761</div> </div> | | | | | | | | | |
|--|--|--|--|--|--|--|----------|---|--|
| 1. DECEASED-NAME (Type or print) | | | | | 20. DATE OF DEATH | | 2b. HOUR | | |
| First Middle Last
Luzetta - MEARS | | | | | Month Day Year
3 9 68 | | 1:15p M | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
2/2/29 | | 6. AGE (In years lost birthday)
39 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH
Owings Mills | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Rosewood State Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Dependent | | 12b. KIND OF BUSINESS OR INDUSTRY
none | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Baltimore | | 13c. CITY OR TOWN
Baltimore | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1501 North Hilton Street | |
| 14. FATHER'S NAME First Middle Last
Howard - Mears | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Ida Walpert | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) -- | | | 16b. SOCIAL SECURITY NO.
- | | 17. INFORMANT Address
Rosewood Records, Owings Mills, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis
174X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 170X
(b) Carcinoma of Right Breast
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 year
1 year | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
institutionalization 14 yrs, Cerebral infarct at birth | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from 7/24 , 19 44 , to 3/9 , 19 68 , that (a) (we) last saw the deceased alive on 3/9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (didn't) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Richard A. Jones | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
3/11/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Richard A. Jones, M.D. | | | | 22e. ADDRESS
Rosewood St. Hosp., Owings Mills, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
3/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Grotons | | 23d. LOCATION (City or Town) (County) (State)
HALLWOOD, ACCOMACK, VA. | | | |
| 24. FUNERAL DIRECTOR
Hubbard Funeral Home | | | | ADDRESS
4107 Wilkins Ave | | 25a. REC'D BY REGISTRAR
MAR 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Jones | |

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DATE TIME OF DAY: 01/10/2000 12:00:00

Single author

doi:10.1017/S0022292412001609

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

VR A15-4
30M REV. 1/68

| <div>03780</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>03762</div> | | | | | | | | | | | | | | | |
|---|--|------------------------------|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) | | | | First Middle Last | | | | 20. DATE OF DEATH | | | | 2b. HOUR | | | |
| JAMES | | | | WILLIAM | | | | MEEHAN | | | | MARCH Month 27, Day 1968 Year 3:35 ^A | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | |
| MALE | | WHITE | | NOVEMBER 5, 1894 | | | | 73 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md. | | | |
| MARYLAND | | U.S.A. | | | | BALTIMORE, | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| TOWSON | | | | ST. JOSEPH HOSPITAL | | | | Office Manager (Retired) | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Md. | | | | | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5000 Lodestone Way | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | |
| Unknown | | | | Unknown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | | | | |
| No | | | | 213-05-0131 | | Mr. William Meehan, 2209 Fleetwood Ave. #14 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Subarachnoid hemorrhage | | | | | | | | | | | | | | | |
| 4309 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | |
| (b) rupture of berry aneurysm | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 330X | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 16, 1968, to MARCH 27, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MARCH 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | Ines Cilliari, M.D. | | | | 22c. DATE SIGNED | | March 27, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | Ines Cilliari, M.D. | | | | 22e. ADDRESS | | 7620 York Rd., Towson, Md. 21204 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 3/30/68. | | Holy Redeemer Cemetery | | | | Baltimore, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Leonard J. Ruck, Inc. Balto. Md. 21214 | | | | | | | | DATE | | MAY 28 1968 Charles Judge | | | | | |

MEDICAL CERTIFICATION

03183

03183



03183

03183

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | |
|---|--|----------------------|--|---|--|--|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) <i>Burn</i> First <i>Pitt</i> Middle <i>Meise</i> Last | | | 2a. DATE KNOWN <input checked="" type="checkbox"/> Month <i>MAR</i> Day <i>13</i> Year <i>1968</i> | | | 2b. HOUR <i>M</i> | | | | | | | | | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>10/14/20</i> | | 6. AGE (In years last birthday) <i>47</i> YRS. | | 7c. DATE PRONOUNCED DEAD
Month <i>MAR</i> Day <i>13</i> Year <i>1968</i> | | 2d. HOUR <i>M</i> | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Baltimore</i> Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Elkridge Estates</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>6011 HUNTRIDGE RD</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Hostess</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Funeral Home</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>Baltimore</i> | | 13c. CITY OR TOWN <i>Elkridge</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>6011 Huntridge Rd., Elkridge</i> | | | | | | |
| 14. FATHER'S NAME First <i>William</i> Middle <i>Arthur</i> Last <i>Darby</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Lilian</i> Middle <i>B.</i> Last <i>Pitt</i> | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. <i>218-34-0387</i> | | 17. INFORMANT ADDRESS <i>Lilian B. Darby, 6011 Huntridge Rd., Elkridge</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i>
<i>4109</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4201</i> | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. _____ P.M. <i>19</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>William A. Pilsbury</i> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED <i>3-13-68</i> | | | | | | | | |
| EXAMINER'S NAME (Type) <i>William A. Pilsbury</i> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, City, Town, or County) _____ | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | | | 23b. DATE <i>3/16/68</i> | | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | | | 23d. LOCATION (City or Town) <i>Baltimore</i> (County) _____ (State) <i>Md.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i> | | | | | | | | 25a. REC'D BY REGISTRAR <i>Charles J. Jones</i> | | | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i> | | | | |
| DATE <i>MAR 18 1968</i> | | | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) LILY B. MENCHINE | | | | | 2a. DATE OF DEATH March Month 31 Day 1968 Year | | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE Cau. | | 5. DATE OF BIRTH March 10, 1875 | | 6. AGE (In years last birthday) 93 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Washington, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Md. | | | |
| 10. CITY OR TOWN OF DEATH Baltimore 21234 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1117 Pelham Wood Road | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 1117 Pelham Road | |
| 14. FATHER'S NAME First Middle Last Conrad Faunce | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Neitzey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 213-48-2154 | | 17. INFORMANT Judge W. Albert Menchine, Address Manor Rd. Glen Arm. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Bladder
188X
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1810 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 2, 1967 , to Mar 31, 1968 , that (I) (we) last saw the deceased alive on March 29, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE George Sawyer M.D. DEGREE <input checked="" type="checkbox"/> ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 4/2/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) GEORGE SAWYER M.D. | | | | 22e. ADDRESS 4808 Harford Rd. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Apr. 3. 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State) Woodlawn, Maryland | | | |
| 24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, ADDRESS 1050 York Road Towson, Maryland 21204 | | | | 25a. REC'D BY REGISTRAR APR 3 - 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

02184

THE CASE OF

02184



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Gerald | | First | | Middle | | Last
Miliner | | 2a. DATE OF DEATH
Month March Day 18 Year 1968 | | | 2b. HOUR
8:50AM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
June 7, 1963 | | | 6. AGE (In years last birthday)
4 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Baltimore, Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Towson | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
ST. JOSEPH HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
None | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
HOWARD | | 13c. CITY OR TOWN
Ellicott City | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
81 Montgomery Rd. | | | | |
| 14. FATHER'S NAME First
Harry | | Middle
W | | Last
Miliner | | 15. MOTHER'S MAIDEN NAME First
Dixie | | Middle
Smith | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
No | | 17. INFORMANT
Harry Miliner | | Address
81 Montgomery Rd. Ellicott City, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute lymphocytic leukemia
204.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
204.3 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. _____ Month _____ Day _____ Year 19
P.M. _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. _____ | | City or Town _____ | | County _____ | | State _____ | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/4/ , 19 68 , to 3/18/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3/18/ , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Imelda B. Salanio | | | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
March 18, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
Imelda B. Salanio, M.D. | | | | 22e. ADDRESS
7620 York Rd., Towson, Md. 21204 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
3-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY
St Johns | | 23d. LOCATION (City or Town)
Ellicott City, Md. | | (County) | | (State) | | |
| 24. FUNERAL DIRECTOR
Agimbohem-Slack
Ellicott City | | | | ADDRESS
Ellicott City Md | | 25a. REC'D BY REGISTRAR
DATE MAR 22 1968 | | 25b. REGISTRAR'S SIGNATURE
Imelda Salanio | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
30M REV 7/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Clara M. Miller | | | | | | 3-12-68 | | | 10:00 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Female | | Cauc. | | 12-8-1880 | | | 87 | | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Germany | | U.S.A. | | | | Balto. Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Baltimore | | | 315 Greenlow Rd., Balto., Md. | | | Housewife | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Balto. | | Balto. | | YES | | 315 Greenlow Rd., Balto. 21228 |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| William Mayenberger | | | | Elizabeth Seeli Mayenberger | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | -- | | Miss Hilda E. Miller, 315 Greenlow Rd., Balto. Md. 21228 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Alters stroke C.V.D.</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | 10 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4271 <u>Rheumatoid Arthritis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 1960, to March 12, 1968, that (I) (we) last saw the deceased alive on March 11, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. J. Nelson McKay</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED March 13, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. J. Nelson McKay | | | | 22e. ADDRESS 6014 Edmondson Ave., Balto. Md. 21228 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3-16-68 | | New Cathedral Cemetery | | Balto., Md. | | | |
| 24. FUNERAL DIRECTOR 4101 Edmondson Avenue Witzke Funeral Directors, Balto., Md. 21229 | | | | 25a. REC'D BY REGISTRAR DATE MAR 14 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

0370b

OFFICE OF THE ATTORNEY GENERAL

0370b

STATE OF ALABAMA
IN SENATE
January 11, 1960
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF REVENUE
AND
TREASURY
FOR THE YEAR
ENDING DECEMBER 31, 1959
BY
J. L. HARRIS
COMMISSIONER

ALABAMA DEPARTMENT OF REVENUE AND TREASURY
BIRMINGHAM, ALABAMA
JANUARY 11, 1960

ALABAMA DEPARTMENT OF REVENUE AND TREASURY
BIRMINGHAM, ALABAMA
JANUARY 11, 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|---|---------------------------------|--|--|---|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | | | |
| LEONARD | | | MILLER | | | MARCH 1 | | | 1968 1:10 AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| MALE | | WHITE | | SEPT. 12, 1912 | | | 55 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| BALTIMORE, MD. | | | U.S.A. | | | | | | BALTIMORE Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| PIKESVILLE | | | 7025 DEERFIELD ROAD | | | SUPERVISOR | | | POST OFFICE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| MARYLAND | | | BALTIMORE | | | PIKESVILLE | | | 7025 DEERFIELD ROAD | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| HARRY MILLER | | | LENA HEYMAN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | | |
| NO | | | 213-01-8544 | | | MRS. EVELYN MILLER, 7025 DEERFIELD RD | | | #21208 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Dissecting Ruptured Aorta</u>
<u>401X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Dissecting Aneurysm</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr</u>
<u>2 2/4</u>
<u>7 yrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>444X</u> <u>Generalized Arteriosclerosis</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>61</u> , to <u>2/29</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | |
| <u>George Ramapuram</u> | | | | | | | | | <u>3/1/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | |
| GEORGE RAMAPURAM | | | 3502 CROYDON ROAD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | | 3-3-68 | | | BNAI ISRAEL | | | BALTIMORE, MARYLAND | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | 25a. REC'D BY REGISTRAR DATE | | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | | MAR 5 1968 | | | <u>Charles J. Jones</u> | | | | | | |

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--------------------|--|--|---|---|--|--|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) ANNIE Elizabeth MOHR | | | | | | 2a. DATE OF DEATH
Month 3 Day 28 Year 68 | | | 2b. HOUR 9.05 AM | | |
| 3. SEX F | | 4. RACE CAU | | 5. DATE OF BIRTH 8-28-1913 | | | 6. AGE (In years last birthday) 54 YRS. | | IF UNDER 1 YEAR
MONTHS 5 DAYS 10 | | IF UNDER 24 HRS.
HOURS 9 MIN. 05 |
| 7a. BIRTHPLACE (State or foreign country) Balto. Md. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Balto County Md. | | |
| 10. CITY OR TOWN OF DEATH Towson | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greater Balto. Med. Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY N.A. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. COUNTY Balto. | | | 13c. CITY OR TOWN Balto | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Rt. 16 Box 197 | | | |
| 14. FATHER'S NAME First GEORGE Middle Pugh Last Pugh | | | | 15. MOTHER'S MAIDEN NAME First Gladys Middle Biddison Last Biddison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 218-03-3446 | | | 17. INFORMANT PATIENT CHART | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cachexia.
151.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) CX of the stomach with liver metastases
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
151X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-7-1968 , to 3-28-1968 , that (I) (we) last saw the deceased alive on 3-28-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Spurita Colledo, M.D. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | | | | 22c. DATE SIGNED 3-28-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Spurita Colledo, M.D. | | | 22e. ADDRESS Greater Baltimore Medical Center | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 4-1-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Baltimore Co. Md. | | | |
| 24. FUNERAL DIRECTOR Lessch Terminal Home 2401 Belair Road | | | ADDRESS 31236 | | | 25a. REC'D BY REGISTRAR DATE APR 1 - 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019 2020 2021 2022 2023 2024 2025 2026 2027 2028 2029 2030 2031 2032 2033 2034 2035 2036 2037 2038 2039 2040 2041 2042 2043 2044 2045 2046 2047 2048 2049 2050 2051 2052 2053 2054 2055 2056 2057 2058 2059 2060 2061 2062 2063 2064 2065 2066 2067 2068 2069 2070 2071 2072 2073 2074 2075 2076 2077 2078 2079 2080 2081 2082 2083 2084 2085 2086 2087 2088 2089 2090 2091 2092 2093 2094 2095 2096 2097 2098 2099 2100 2101 2102 2103 2104 2105 2106 2107 2108 2109 2110 2111 2112 2113 2114 2115 2116 2117 2118 2119 2120 2121 2122 2123 2124 2125 2126 2127 2128 2129 2130 2131 2132 2133 2134 2135 2136 2137 2138 2139 2140 2141 2142 2143 2144 2145 2146 2147 2148 2149 2150 2151 2152 2153 2154 2155 2156 2157 2158 2159 2160 2161 2162 2163 2164 2165 2166 2167 2168 2169 2170 2171 2172 2173 2174 2175 2176 2177 2178 2179 2180 2181 2182 2183 2184 2185 2186 2187 2188 2189 2190 2191 2192 2193 2194 2195 2196 2197 2198 2199 2200 2201 2202 2203 2204 2205 2206 2207 2208 2209 2210 2211 2212 2213 2214 2215 2216 2217 2218 2219 2220 2221 2222 2223 2224 2225 2226 2227 2228 2229 2230 2231 2232 2233 2234 2235 2236 2237 2238 2239 2240 2241 2242 2243 2244 2245 2246 2247 2248 2249 2250 2251 2252 2253 2254 2255 2256 2257 2258 2259 2260 2261 2262 2263 2264 2265 2266 2267 2268 2269 2270 2271 2272 2273 2274 2275 2276 2277 2278 2279 2280 2281 2282 2283 2284 2285 2286 2287 2288 2289 2290 2291 2292 2293 2294 2295 2296 2297 2298 2299 2300 2301 2302 2303 2304 2305 2306 2307 2308 2309 2310 2311 2312 2313 2314 2315 2316 2317 2318 2319 2320 2321 2322 2323 2324 2325 2326 2327 2328 2329 2330 2331 2332 2333 2334 2335 2336 2337 2338 2339 2340 2341 2342 2343 2344 2345 2346 2347 2348 2349 2350 2351 2352 2353 2354 2355 2356 2357 2358 2359 2360 2361 2362 2363 2364 2365 2366 2367 2368 2369 2370 2371 2372 2373 2374 2375 2376 2377 2378 2379 2380 2381 2382 2383 2384 2385 2386 2387 2388 2389 2390 2391 2392 2393 2394 2395 2396 2397 2398 2399 2400 2401 2402 2403 2404 2405 2406 2407 2408 2409 2410 2411 2412 2413 2414 2415 2416 2417 2418 2419 2420 2421 2422 2423 2424 2425 2426 2427 2428 2429 2430 2431 2432 2433 2434 2435 2436 2437 2438 2439 2440 2441 2442 2443 2444 2445 2446 2447 2448 2449 2450 2451 2452 2453 2454 2455 2456 2457 2458 2459 2460 2461 2462 2463 2464 2465 2466 2467 2468 2469 2470 2471 2472 2473 2474 2475 2476 2477 2478 2479 2480 2481 2482 2483 2484 2485 2486 2487 2488 2489 2490 2491 2492 2493 2494 2495 2496 2497 2498 2499 2500 2501 2502 2503 2504 2505 2506 2507 2508 2509 2510 2511 2512 2513 2514 2515 2516 2517 2518 2519 2520 2521 2522 2523 2524 2525 2526 2527 2528 2529 2530 2531 2532 2533 2534 2535 2536 2537 2538 2539 2540 2541 2542 2543 2544 2545 2546 2547 2548 2549 2550 2551 2552 2553 2554 2555 2556 2557 2558 2559 2560 2561 2562 2563 2564 2565 2566 2567 2568 2569 2570 2571 2572 2573 2574 2575 2576 2577 2578 2579 2580 2581 2582 2583 2584 2585 2586 2587 2588 2589 2590 2591 2592 2593 2594 2595 2596 2597 2598 2599 2600 2601 2602 2603 2604 2605 2606 2607 2608 2609 2610 2611 2612 2613 2614 2615 2616 2617 2618 2619 2620 2621 2622 2623 2624 2625 2626 2627 2628 2629 2630 2631 2632 2633 2634 2635 2636 2637 2638 2639 2640 2641 2642 2643 2644 2645 2646 2647 2648 2649 2650 2651 2652 2653 2654 2655 2656 2657 2658 2659 2660 2661 2662 2663 2664 2665 2666 2667 2668 2669 2670 2671 2672 2673 2674 2675 2676 2677 2678 2679 2680 2681 2682 2683 2684 2685 2686 2687 2688 2689 2690 2691 2692 2693 2694 2695 2696 2697 2698 2699 2700 2701 2702 2703 2704 2705 2706 2707 2708 2709 2710 2711 2712 2713 2714 2715 2716 2717 2718 2719 2720 2721 2722 2723 2724 2725 2726 2727 2728 2729 2730 2731 2732 2733 2734 2735 2736 2737 2738 2739 2740 2741 2742 2743 2744 2745 2746 2747 2748 2749 2750 2751 2752 2753 2754 2755 2756 2757 2758 2759 2760 2761 2762 2763 2764 2765 2766 2767 2768 2769 2770 2771 2772 2773 2774 2775 2776 2777 2778 2779 2780 2781 2782 2783 2784 2785 2786 2787 2788 2789 2790 2791 2792 2793 2794 2795 2796 2797 2798 2799 2800 2801 2802 2803 2804 2805 2806 2807 2808 2809 2810 2811 2812 2813 2814 2815 2816 2817 2818

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| <div>4</div> <div>03787</div> <div>03769</div> | | | | | | | | | | | | | | | | | | | |
|---|--|--|------------------------------|--|--|--|--|---|---------------------------------|--|--|--|--|-------------------------------------|--|--------------------------|--|------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | |
| JENNINGS | | | | | | | | | | MOORE | | Month 3 Day 17 Year 68 | | 12:20 AM | | | | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | |
| MALE | | | White | | | July 13/22 | | | 45 YRS. | | | MONTHS | | DAYS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | |
| West Virginia | | | U.S.A. | | | | | | Baltimore County, Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Mt. Wilson | | | | Mt. Wilson State Hosp. | | | | Messenger Clerk | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | Prince Geo. Co. | | Oxon Hill | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 341 Irvington | | | | | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First | | Middle | | Last | |
| Steve | | | | R. | | | | Moore | | Maude | | | | | | | | Fulford | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | | | | | Address | | | |
| | | | | | | | | Records, Mt. Wilson State Hospital | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONFLUENT BRONCHOPNEUMONIA, | | | | | | | | | | | | | | | | | | | |
| 485X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | |
| 491X PULMONARY EMPHYSEMA | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| | | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION | | | | Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 15, 1968, to March 17, 1968, that (I) (we) last saw the deceased alive on March 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR | | STAFF PHYS. | | 22c. DATE SIGNED | |
| Wm. Newcomer | | | | | | | | | | | | <input type="checkbox"/> | | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | | MAY. 17-1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | |
| Mox Wm. Newcomer, M.D. | | | | | | | | | | Mount Wilson, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | |
| Burial | | | | March 20-68 | | Washington National | | | | Suitland, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Simmons Bros | | | | | | | | | | 1661 Good Hope Rd | | MAR 19 1968 | | Charles Jones | | | | | |

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Dr. J. H. H. H.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03788

03771

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Helen AGNES Mullen. | | | 20. DATE OF DEATH
Month 3 Day 26 Year 68 | | | 2b. HOUR 5:45 AM | |
| 3. SEX F | | 4. RACE Cau. | | 5. DATE OF BIRTH
8-3-05 | | 6. AGE (In years last birthday) 62 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Pa. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Baltimore Co. Md. | |
| 10. CITY OR TOWN OF DEATH Towson. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Gr. Med. Balto. Center | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md. | | 13b. COUNTY B. Co. | | 13c. CITY OR TOWN Pikesville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER 3 Walker Ave. | | | | | | | |
| 14. FATHER'S NAME First Albert Middle Shelters Last Quinn | | | 15. MOTHER'S MAIDEN NAME First Elizabeth Middle Quinn Last Quinn | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. Na | | 17. INFORMANT PTs. history Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1621
DUE TO, OR AS A CONSEQUENCE OF (b) extensive metastasis 2° to
DUE TO, OR AS A CONSEQUENCE OF (c) undiff. small cell ca of bronchogenic ca
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1621 | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION 3/14/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRONCHOSCOPY | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-5 , 19 68 , to 3-26 , 19 68 , that (I) (we) last saw the deceased alive on 3-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Lilia C. Baldonado DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED 3-26-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) LILIA C. BALDONADO | | | | 22e. ADDRESS GBMC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE March 29, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Forest Hills | | 23d. LOCATION (City or Town) (County) (State) Pikesville Baltimore Md | |
| 24. FUNERAL DIRECTOR Frank H. Howell | | 24a. REC'D BY REGISTRAR APR 1 1968 | | 24b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03783

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03772

| | | | | | | | | | |
|--|------------------------------|--|--|--|---------------------------------|--|-----------------------|--|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Joseph | | | ----- | Musil Jr. | March Month 24 Day 1968 Year | | 7 P.M. | | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| Male | White | | Sept. 24, 1887 | | 80 YRS. | | MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | U.S.A. | | | | Baltimore Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Randalstown | | Chapel Hill Nursing Home | | Policeman (Retired) | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | Baltimore | | | | 2913 E. Baltimore Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | First Middle Last | | | | | | | |
| Joseph --- Musil, Sr. | | Anna Clement | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | 220-44-2056 | | Grace Paplauskas 2913 E. Balto. St. Balto. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① C.V.A. in L. side | | | | | | | | 3 days | |
| 4389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hemiplegia | | | | | | | | | |
| (c) ② Generalized Arteriosclerosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 331X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-12-1967, to 3-24-1968, that (I) (we) last saw the deceased alive on 3-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Cesar Valle Caverio M.D. DEGREE | | | | | | | | 22c. DATE SIGNED 3-25-68 | |
| 22d. PHYSICIAN'S NAME (Type) CESAR VALLE CAVERIO | | | | | | | | 22e. ADDRESS 8629 Liberty Rd | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 3/27/68 | | Holy Redeemer Cemetery | | Baltimore Maryland | | | |
| 24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Balto. St. | | | | 25a. REC'D BY REGISTRAR DATE MAR 29 1968 | | 25b. REGISTRAR'S SIGNATURE | | | |
| | | | | | | | | | |

MEDICAL CERTIFICATION

0250

1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

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